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ABSTRACT

A study identified and explored the changing educational needs of mental health and learning disability nurses in Britain following the 1990 National Health Service and Community Care Act. A literature review focused on service developments in mental health and learning disability nursing and changes in education. Interviews were conducted with 147 stakeholders at 6 sites. Requirements for skilled practice for mental health and learning disability nurses were identified. These requirements and implications for education were categorized under seven themes: working with others; clinical practice; learning formats; user enablement and empowerment; responding to the market and service priorities; values; and impact of new models of care. For each theme, findings were grouped into those that pertained to both mental health and learning disability nurses, followed by those that emerged for each group separately. Implications for education were as follows: curriculum content that emphasized clinical assessment at the individual, family, and community level; clinical knowledge and supervised practice that enhances self-assessment, self-confidence, and initiative; student exposure to different service delivery models; role development; and managing change. Five models of educational preparation were identified. Two were independent of each other: specialist and generic. The other three were variations of these two: pragmatic, unity-of-nursing, and social care. (Appendixes contain 235 references, site descriptions, instruments, and data.) (YLB)

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QUALITY EDUCATION • FOR QUALITY CARE •

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THE CHANGING EDUCATIONAL NEEDS OF MENTAL HEALTH AND LEARNING DISABILITY NURSES

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THE CHANGING EDUCATIONAL NEEDS OF MENTAL HEALTH AND LEARNING DISABILITY NURSES

PREFACE

The Board is pleased to publish the report which has explored the educational needs of mental health and learning disability nurses in the context of changes in healthcare provision, and the implementation of the NHS and Community Care Act, 1990. The implications of the Act for service and education needs were analysed in relation to contemporary education and practice and the perceptions of a wide range of stakeholders were obtained.

Through a variety of means the Board ensures that education for practice continues to be relevant both professionally and academically. Research based evidence from this and other reports provides another important dimension in the development of educational policy. The implications of the findings and conclusions within this report will be carefully considered in future policy decisions.

The report will be of interest to education providers, commissioners of education, practitioners and managers. Developments in education will ultimately improve the quality of care delivered to service users.

Maureen Theobald

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CHAPTER 1
THE GENESIS AND PURPOSE OF THE PROJECT

The Nursing Research Unit and the Department of Nursing Studies at King's College London were commissioned in March 1993 by the English National Board for Nursing, Midwifery & Health Visiting to conduct a project that would investigate the changing educational needs of mental health (MH) and learning disability (LD) nurses following implementation of the NHS & Community Care Act (1990). The responsibilities of mental health and learning disability nurses have been radically altered by the Act and associated community reforms. The closure of psychiatric and mental handicap hospitals, the emphasis on community rather than hospital care and the distinction between health and social care for people in the community, with its funding implications, have demanded that nurses face the challenges of developing new skills and new ways of working. The focus of this project was to explore the impact of the reforms on nurses and their practice, and to identify the implications of these for the education of mental health and learning disability nurses.

1.1 BACKGROUND AND RATIONALE

It has been the policy thrust of successive Governments for over thirty years to reorientate mental health service provision away from institutions, toward community settings (Powell 1961, DHSS 1975, 1981). The NHS & Community Care Act has reinforced a continuing commitment to community care and has defined the general mechanisms through which it ought to be delivered. The many client groups targeted to benefit from community care include people with a learning disability and/or a mental illness.

Both client groups have witnessed a substantial reduction in the number of people who have been placed in long-term residential care. The care provided in these settings, however, has continued as an important part of service provision for each. In England, approximately 25,000 people with learning disability (Cullen 1991) are cared for by about 13,000 wte NHS nurses and 17,000 support workers, in NHS hospitals (Department of Health 1991a). About 61,000 (Department of Health 1992a) people with mental illness are resident in hospitals cared for by 33,000 wte nurses and 18,000 support workers (Department of Health 1991a). It has been estimated (White 1991a) that some 4,300 community psychiatric nurses work in England with about 146,000 mentally ill clients in non-hospital settings. And about 1,500 (Department of Health 1991a) community mental handicap nurses work with some 30,000 clients with learning disability (Lahiff 1992).

In broad terms, therefore, community nursing staff represent a comparatively small proportion of the total qualified workforce of each specialty (about 10-15%), but care for a disproportionately large number of clients (notwithstanding the variation in dependency levels between hospital and community clients). At a time of hospital closure programmes, these relative proportions, and their absolute numbers, continue to change in the direction of community based services and community based nursing staff.

The implementation of *Caring for People: community care in the next decade and beyond* (Department of Health 1989a) has given lead responsibility for the management of community support to people with learning disability and mental health problems to local authorities and it is as yet unclear what advantage social services departments find in the large scale deployment of mental health professionals (including nurses) in local authority based support services (Beardshaw & Robinson 1990). As negotiations continue to unfold, therefore, the contribution of nursing to the care of both client groups, in hospital and non-hospital settings, has presented a relentless challenge to service planners and their educational counterparts.

Much of the current debate has focused on the shape of service provision, on a review of the skill-mix and quality assurance and clarification of possible nursing roles within multi-professional community based services (e.g. Department of Health 1989b, All Wales Nurse Group for People with Mental Handicap 1992). Multi-professional education and training, therefore, has become the corollary, although its widespread and successful establishment remains elusive (Goldberg & Huxley 1992). The English National Board (ENB) and the Central Council for the Education and Training of Social Work (CCETSW) agreed a joint strategy which set out current and future collaborative initiatives (ENB 1992). The work programme of the strategy for 1992/3 included a review of joint working in the area of learning disabilities, together with an intention to publish a report '. . . on good practice, in order to promote sharing across the professions'.

The report by the All Wales Nurse Group for People with Mental Handicap (1992) supports an emphasis on shared and joint training, although it questions whether the recommended generic practitioner (Cullen 1991) can hold the full range of skills necessary for provision of truly comprehensive care. Evenso, the development of joint training in learning disability nursing and social work has continued at pre- and post-registration level (Elliott-Cannon & Harbinson 1995).

Most nurses now are prepared for practice through one of the four branches of the Diploma in Education (DipHE) courses (United Kingdom Central Council 1986), including mental health and learning disability. Each course is structured by an initial 18-month Common Foundation Programme (CFP), shared between all students, before they enter a chosen branch. DipHE courses intend to prepare diplomates to work in both hospital and community settings.

Two studies, commissioned by the ENB, increased the knowledge available on mental health nursing. In one (White 1991b) a panel of experts was invited to forecast the future of psychiatric nursing by the year 2000. They predicted a substantial reduction in the number of entrants to the mental health branch of DipHE courses and that a new post-basic course in community psychiatric nursing will become a mandatory prerequisite for practice as a community psychiatric nurse. In the other study (White 1991a), the present educational preparation of community psychiatric nurses was reported not to have been examined at a national level in the 18 years since its inception. Little was thus known about the orientation, efficacy or cost-effectiveness of this type of preparation, nor its relevance to practice. Recent publications (Department of Health 1990a, 1992b, Royal College of Psychiatrists 1992) have identified seriously mentally ill people as the priority client group for service provision. White and Brooker (1991) anticipated this policy and discussed what it might imply for community psychiatric nursing practice and education in the future, while White (1991c) suggested what it might also imply for others.

The role of mental health and learning disability nurses has been under scrutiny since the closure of the psychiatric and mental handicap institutions in a way that did not arise in the hospital setting. Whether nursing should continue to exist in its current form in these two areas is continuing as a subject for much debate. Also education; should students be prepared much as before, with an allegiance to single professional status, but with amendments to the curricula to take account of the community emphasis? Should there be a much more radical change into joint training or shared learning? Or should a variety of options be available to prepare practitioners to work in different settings and specialties? Multi-professional team working is regarded as essential for high quality service provision (White 1991c) and so we have to ask whether specialist, joint or shared education and training will produce a practitioner most likely to contribute effectively to team work.

Such is the unequivocal priority of seriously mentally ill people for mental health service provision, that contractors in health authorities will wish to make sound and discriminating judgements about both the level and type of educational preparation of nursing staff necessary to meet local requirements. Indeed, *Working Paper 10* set out the education and training implications of the *Working for Patients* White Paper (Department of Health 1990b) and confirmed that specialist skilled staffing and associated training were the hallmarks of quality which providers should demonstrate to prospective purchasers of services. From April 1993, social services departments became the purchasers of services for people with mental illness and learning disability. One important consequence of this change is that purchasing decisions follow joint assessment events, involving both health and social services personnel.

Such activity provides an example of two predictable educational consequences: the development of a capacity for multi-agency, multi-professional collaboration and the acquisition of high quality assessment skills. The bases upon which these and other such curricular decisions can be made with confidence, for both mental health nursing and learning disability nursing, for practice inside and outside institutional settings, are in development and we hope will be greatly assisted by the findings from this study.

During the course of this study, two important reviews reported their findings: the review of mental health nursing (Department of Health 1994) and of learning disability nursing (Kay *et al* 1995). Lessons to be learned from these reports are considered in the final chapter on our findings, Chapter 6.

1.2 AIMS AND OBJECTIVES

The aims of the study were to:

a) identify the changing educational needs of nurses at pre- and post-registration levels involved in the practice of mental health and learning disability nursing in different settings;

b) make recommendations to the English National Board in relation to the development of educational programmes at pre- and post-registration levels for mental health and learning disability nurses.

Specific objectives were to:

a) identify community care settings characterised by progressive care practices which reflect the substance and spirit of the NHS & Community Care Act (1990);

b) explore service implications of the Act for practice and the relevance to contemporary educational provision as perceived by mental health and learning disability nurses and other stake-holders drawn from purchasing authorities provider units, service users and educational establishments.

1.3 OVERVIEW AND APPROACH TAKEN

The research design and methods - described in detail in Chapter 4 - followed a process of empirical enquiry, to discover the views of mental health and learning disability stake-holders, and development work to build models of educational provision to inform policy makers, educationists and practitioners. In undertaking this process of field research and development, we have engaged in the following activities:

- found key informants whose perspectives were important in identifying the substantive issues about service provision and their educational implications;

- explored provision of services from the perspective of different stake-holders (care providers, managers, purchasers, lecturers, students, service users, carers, advocates) in three mental health and three learning disability services in England selected for their diversity;

- discovered views that emerged from the data, for mental health and learning disability, which we describe in terms of their service, practitioner and educational implications;

- drawn issues from the views and clustered them into categories and themes;

- specified the implications of the findings for education of mental health and learning disability nurses;

- built normative models of nursing education for consideration and debate.

1.4 OUTLINE OF THE REPORT

In this chapter we have described the genesis and purpose of the project and a brief overview of the research approach we took.

Chapters 2 and 3 review the literature on service developments in mental health and learning disability nursing (Chapter 2) and on the changes in education that have occurred over the years (Chapter 3). Chapter 2 traces the transition over the last 30 years from hospital to community based services for people with mental illness and learning disabilities. It reviews the changes in care ideologies, the scrutiny of professional role boundaries and the implications for users and professionals of a market-led service.

Chapter 3 considers developments in mental health and learning disability nursing education. Particular attention is given to the impact of the DipHE reforms, the development of training for support workers and the links between social work and nursing.

Chapter 4 describes the design of the study and the methods used. It recalls the process of consultation leading to selection of the study sites, and the nature and content of the fieldwork undertaken. And it explains how the data were handled and analysed and the way they have been summarised in Chapter 6 and exploited for the development of models in Chapter 7. An overview of the six sites is presented as an appendix, containing: the organisational structure of the service, contracting and purchasing, links with educational establishments and the purpose of the service.

Chapter 5 draws from the detailed presentation of empirical findings located in appendices. It highlights requirements for skilled practice for mental health and learning disability nurses.

Chapter 6 draws together the data into categories and themes which summarise the major issues facing mental health and learning disability nurses as described by our respondents. In extracting the implications of these findings for nursing education we draw upon our discussions with key informants throughout the course of the study. The final chapter, Chapter 7, brings together general propositions from the research in specifying the important content of nurse education based on the aspects of skilled practice described earlier. We take a forward look by building models of nursing education for consideration by the professions and we reflect on future directions of education for mental health and learning disability nursing.

We hope that our report will increase understanding of mental health and learning disability nursing work in community based services and the implications for education. The study took place during a time of turbulence for the profession when service and education providers were struggling to cope with the changes from the Act and to improve quality. This report develops current ideas on future education for these two groups of nurses and seeks to provide a basis on which providers might develop educational programmes.

CHAPTER 2

THE TRANSITION TO A COMMUNITY BASED SERVICE

This chapter sets the scene by charting the transition from hospital to community based services for people with mental illness* and learning disabilities* over the past 30 years. It signals the major policy influences on the development of services, changing approaches to care and sketches the environment within which development has taken place.

2.1 BEGINNINGS

From the early 1960s the, then Conservative, government had been concerned with what it saw as the need to restructure a national health service weighed down by a disproportionate number of patients suffering from psychiatric disorders and mental disability. Over 40% of hospital beds were taken up by these patients and, in an attempt to reduce this, the *Hospital Plan for England and Wales* (Ministry of Health 1962) proposed to restrict hospital services largely to the acute sector of medicine. Only chronically disabled people suffering from mental illness, learning or physical disability, and the elderly infirm would go into hospital. The rest could be treated in the community (Jones 1993).

The belief that the community offers the best haven for such people was allied to the majority view that drugs offered a genuine opportunity for the control of symptoms and, in some cases, cure. Pharmacotherapy strengthens the argument for mental disorders to be treated as medical issues but a number of prominent psychiatrists agreed with the government that hospital care is inappropriate (McKeown *et al* 1958). This change of emphasis in service provision was accompanied by attempts by several mental health professions to ascend to a position of prominence (Jones 1993). Training packages were created to promote the need for skills and qualifications but most of these still placed great emphasis on medical aspects, particularly the biological aspects of psychiatric illness and mental disability (Salvage 1985). Consequently they represented little threat to the dominance of doctors.

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*Throughout this report we have referred to 'mental illness' and 'learning disability' rather than changing the terms to reflect the historical period being discussed. This bypasses the controversy and confusion that has occurred as these terms have changed over time. We acknowledge that the terminology has changed its meaning too, from the medical emphasis on 'psychiatric illness' and the derogatory labels of 'educationally subnormal' and 'mentally handicapped'. The proposal in the Warnock Committee's Report in 1978 to use 'learning difficulties' seems now to be used interchangeably with 'learning disabilities'.

It was in the 1960s that the anti-psychiatry movement was at its highest. Leading figures in the movement - Laing, Szasz, Sedgewick and Foucault - came from very different philosophical and political positions but were united in their mistrust and scepticism of orthodox psychiatry and challenged it to re-examine its 'history, origins, claims and achievements' (Nolan 1993: 1). Anti-psychiatrists saw psychiatry as performing a role of social control and so could not claim to be a branch of medicine nor a respectable science (Szasz 1985). Szasz (1961, 1972, 1973) argued that defining what are really moral and ethical problems in living as 'mental illnesses' gives the 'therapeutic state' unacceptable power of regulation and control over people's lives.

The anti-psychiatrists were criticised for underestimating the effectiveness of modern psychiatry in diagnosing and treating mental illness and for overestimating its control function (Chapman 1992). Clare (1982) maintained that, to claim the status of a medical science, psychiatry must affirm its base in the biological sciences and resist affiliation to other disciplines (sociology, psychology, anthropology) because these alternatives were not proven as the best approach to understanding mental illness. Others argued that the effort by psychiatry to establish itself as a discipline with theories and models is a mistake (e.g. Vanier 1989, cited by Nolan 1993). What mentally ill and handicapped people need, they maintained, is a therapeutic listener who develops compassion and understanding of people's pain and conveys to them that they are cared for (Nolan 1993). This surely describes the role of psychiatric nursing. But conflict and confusion in nursing left it unable or unwilling to take advantage of psychiatry's indecision. The knowledge base of nursing continues as a contentious issue, with one school following psychiatry in claiming that psychiatric nursing should be grounded in the biological sciences, and the other favouring a social science base with an emphasis on interpersonal skills (Nolan 1993).

During the period of the Labour party's term of office in the late 1960s the talk had been of producing 'health service professionals' implying the need to consider societal factors, practical elements of care including the environment, within psychiatric care (Jones 1993). However in 1971 Keith Joseph, as Minister for Health, located psychiatry firmly as a branch of medicine. The prevailing argument now was for two kinds of health provision: traditional psychiatric (medical) health services (hospital based) and services acting in a way supplementary to medicine (community based) (Jones 1993). It seems likely that the allegiance of psychiatry, and in turn psychiatric nursing and to a lesser extent learning disability nursing, to medicine was a major factor responsible for the slow response of these professions to the challenges of community care which arose in the next two decades. Consequently the door was left open for other professionals, notably social workers, to stamp their mark on the shape of community mental health and learning disability services.

2.2 GATHERING MOMENTUM

In this section we look at the catalogue of hospital inquiries and other factors that led to recommendations that large mental and mental handicap hospitals should close, and the outcomes of those recommendations that were to influence care provision during the 1980s and beyond. Also, we summarise approaches to care and the reorganisations in the health and social services provision that occurred during the 1970s.

2.2.1 Institutional abuse and hospital inquiries

The public inquiries of the 1960s and 1970s exposed professional neglect and suffering of mentally ill patients and people with a learning disability who were 'living' in mental and mental handicap hospitals. Nolan (1993) describes the exasperation that nurses and social workers felt with what they saw as the stalling tactics of numerous government reports and they wrote letters in the 1960s to prominent figures who informed the *Times*. The outcome was *Sans Everything: a case to answer* (Robb 1967) which highlighted the suffering of elderly people in long-stay hospitals. *Sans Everything* showed nurses that publicising the ills of mental hospitals and mental handicap hospitals to influential people outside could be more effective than tackling authoritarian and threatened senior nurses. The tradition of secrecy was broken. Nolan (1993) tells us of the nursing assistant's letter to the *News of the World* which led to the Ely Hospital Inquiry published in 1969. Scrutiny of other vulnerable people - children, mentally ill and people with learning disabilities - followed with 17 more public inquiries into the running of Britain's hospitals (Martin 1984).

The government response to the Ely Hospital Inquiry was to set up the Hospital Advisory Service. The HAS would advise hospital authorities, but only when invited by them, on how services could be developed in hospital and the community. The HAS did not have an inspection function (Brown 1992).

This succession of hospital inquiries highlighted the work of the nurse in the way that current child-care inquiries put the spotlight on the role of the social worker as direct care provider (Brown 1992). In the early 1970s Barbara Castle, the Secretary of State for Social Services, announced four new initiatives. The first was the Briggs Report into nurse education and training which recommended a new caring profession for mental

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handicap nurses (Report of the Committee on Nursing 1972). The second was the investigation into the feasibility and implications of the Briggs recommendation which was eventually published as the Jay Report, but not until 1979 (Report of the Committee of Enquiry into Mental Handicap Nursing and Care 1979). The third was to be a review of the role of the consultant psychiatrist in learning disabilities, but this recommendation was subsequently dropped (Brown 1992). The fourth initiative was the National Development Group (NDG), set up to advise the Secretary of State. This group and the learning disabilities element of the Hospital Advisory Service were to become the Development Team for Mental Handicap (DTMH). But the NDG and the DTMH were to disagree on the role of the newly emerging Community Mental Handicap Teams (Brown 1992).

2.2.2 De-institutionalisation

Since the 1950s treatment of mentally ill people in large institutions increasingly has come under attack (Nolan 1993). The structure and organisation of traditional hospitals was gradually seen to be pathogenic as the new therapeutic regimes at the Cassel, Claybury and Fulbourne hospitals demonstrated the benefits of an 'open-door policy' (Nolan 1993) and a partnership approach to care between staff and patients (Chapman 1992).

Goffman's *Asylums* (1961) is a landmark in the history of care of the mentally ill and people with a learning disability, and of the anti-psychiatry movement. His attack on the 'total institution' in the USA, with its emphasis on block treatment, denial of individuality and social distance between staff and patients, caused the USA and the UK to rethink institutional care (Nolan 1993). Other critics in Britain were also condemning conditions in mental hospitals at the time (Barton 1959, Townsend 1962) and in mental handicap hospitals (Morris 1969). Nurses who ran the hospitals felt powerless because they had no decision-making power (Nolan 1993).

In 1961 Enoch Powell, Minister of Health, declared that mental hospitals must close and the development of community care for the mentally ill remained a policy of successive governments. Throughout the 1960s and 1970s only limited progress was made in moving patients from the larger hospitals into community settings, and community care itself lacked conceptual clarity. Community care was not defined by the Labour government in 1975 but the assumption was that it would be based on the primary care team (consisting of GP, health visitor, district nurse and social worker) with hospital based specialist teams catering for in-patients, out-patients and day patients (Nolan 1993).

Nolan reminds us that *Better Services for the Mentally Ill* gave no indication of how community care would be funded nor whether staff would receive training to ensure that it was effective and not merely a transfer of traditional practices. No pilot studies into the management or effectiveness of the proposed policy were proposed.

A similar picture emerges with mental handicap hospitals. The government White Paper, *Better Services for the Mentally Handicapped*, was published in 1971 after the swingeing criticisms of the large institution. The innovative Brooklands Experiment of the 1950s (Tizard 1964) had argued forcefully for client-oriented homes for children with a learning disability and that large institutions prevented a client focused approach. *Better Services for the Mentally Handicapped* outlined clear principles for practice which emphasised individualised care that recognised each person's need for stimulation, social training, education and purposeful employment in achieving maximum potential (DHSS & Welsh Office 1971:40, paras iii, iv & v).

In outlining the better services required, *Better Services for the Mentally Handicapped* focused on the need to reduce hospital in-patients, provide more local services from smaller hospital units, improve quality of care in existing hospital provision, increase residential and day care facilities provided by local authorities and make full use of the joint planning mechanism for collaboration of provision between local and health authorities. The view was that, wherever possible, community care should be family based except where undue family burden is created and then the substitute should be as 'homely' as possible and close enough to allow regular family visits. Local authorities, through directors of social services, were seen as best placed to take lead responsibility for coordinating professional skills and voluntary agencies were encouraged to perform a significant community role. The White Paper's proposed national plan for service provision acts as a useful gauge for progress still. Over the next 20 years there was to be a move to reduce long-stay hospital beds from 52,000 to 27,000 with a corresponding increase in community care provision.

As soon as *Better Services for the Mentally Handicapped* was published, the Campaign for Mental Handicap was formed which declared that the proposed 25-bedded hostels for people discharged from hospital were too large. Hostels of this size would merely replicate the total institution, and would counter the aim for integration into community life. Social isolation would continue (Brown 1992).

It was at this time, in the early 1970s, that the important distinction between care *in* the community and care *by* the community was made (Bayley 1973). When referring to people with a learning disability, care in the community was seen to be a transfer of the same inadequate practices from large to smaller institutions. Care by the community referred to the care provided by families and it was they who should be the target for support and resources. [Care *by* the community when referring to elderly people is seen, by contrast, as health and social services abrogating their responsibilities and leaving family carers to cope without support].

The debate with respect to people with a learning disability was to centre around support for families in the main and also the few who were to remain in hospital. *Better Services for the Mentally Handicapped* proposed that some people still needed 'treatment' and so were better placed in hospital. This was controversial; opponents argued that even severely handicapped people were not ill and therefore hospital was an inappropriate place to live. If they became ill they should be treated in a general hospital like everyone else. The debate about 'treatment' continues in the distinction between 'health care' and 'social care', and applies to the skills of staff as well as the placement (hospital or community).

2.2.3 Outcomes of the hospital closure programme

By the beginning of the 1970s long-stay in-patients with a psychiatric disorder or learning disability had decreased by some 24% since 1961 whereas admissions had increased by 17% over the same period (Ministry of Health 1971). This indicates that psychiatric hospitals were performing two roles: short-term care of people needing supervision of their medication followed by a rapid return to the community, perhaps precipitating re-admission (the revolving door policy) and provision of long-stay hospital facilities for chronically ill patients (mainly the elderly and those with long standing psychotic disorders). It was these long-stay patients who caused, and continue to cause, considerable public concern (Jones 1988).

If hospitals were still catering for the needs of the 'old' long-stay patients, the community, it was argued, would take care of 'new' long-stay service users. Yet this client group often also requires some hospital intervention. A survey of this latter group declared that over one third of 400 patients observed still needed psychiatric hospital services even where community facilities were considered adequate (Mann & Cree 1976). Furthermore, McCreadie *et al* (1983) argued that 62% of 'new' long-stay patients needed either hospital admission or help from community services then not available. The idea that community care, particularly sheltered accommodation, was less institutional than hospital care was challenged (Apte 1968, Carter & Evans 1978) strengthening the call for hospital services to remain.

Although overcrowding and the resident population of large psychiatric hospitals had gradually decreased, by 1975, none had closed. Twenty-seven years after his announcement in 1961 that hospitals must close Enoch Powell reflected on the entrenched bureaucracies of the psychiatric hospitals that prevented even modest changes, let alone closure, being contemplated (Powell 1988 cited in Nolan 1993). Nevertheless, *Better Services for the Mentally Ill* (DHSS 1975) claimed that the government's policy was working. The development of local services with a shift away from hospital provision towards community based social services care was still the target although the White Paper also declared that the hospital would remain the centre for mental health care services for the foreseeable future, that is until adequate community care facilities were in place to prevent 'revolving door' patients.

As well as the hospital based specialist therapeutic team having responsibility for in-patients, out-patient clinics, hostel provision and day care, the White Paper recommended establishing a 24-hour, mobile crisis service to provide short-term respite and recovery. The high profile role promoted for primary health care teams was to incorporate the patient's social needs with an overall medical plan through collaboration between hospital, primary care and the social services. Patients were admitted to hospital, stabilised through medical treatments and, with their drug therapy renewed, returned to the community to be picked up, in most cases, by ill-prepared or equipped GPs (Weller 1985). This lack of preparation contrasts with the view that primary care, nevertheless, represented the most appropriate focus for community care (WHO 1973). Compare this to the targets set by the USA's National Institute of Mental Health which included provision of an out-reach service, crisis intervention, psychosocial rehabilitation, medical and mental health care, support for relatives, advocacy and case management as well as attending to various socioeconomic factors of daily living (Turner & Ten Hoor 1978). It was argued that such a service should be provided continuously and by teams staffed by expert providers delivering a range of interventions as required (Bachrach 1981).

The failure of the approach in Britain was revealed by the depressing rate of relapse and re-admission during this time. Consistently over 40% of patients were re-admitted within one year of discharge, perhaps because hospital treatment failed to prepare them for the community (Anthony *et al* 1972, 1978). The nursing focus remained integral to the medical approach which advocated discharge home once symptoms were controlled. Social workers were then called upon to provide the necessary support for community living thereafter.

The outcomes of day care provision were mixed. On measures such as psychopathology and social functioning, outcomes were consistent with traditional hospital care (Creed *et* *al* 1990). Similar conclusions had been reached in the USA (Wilder *et al* 1966, Herz *et al* 1971). In terms of cost, day care was shown to be much cheaper in Britain (Dick *et al* 1985) and the USA (Fink *et al* 1978) and, more importantly, both clients and carers expressed a preference for this kind of service (Dick *et al* 1985, Michaux *et al* 1974). Provision came mainly in the form of day centres funded by local authorities or day hospitals run by the health service. But lack of resources and poor staffing levels resulted in clients receiving inadequate provision (Weller 1993). Some services were used as meeting places which offset some of the negative outcomes and ensured reasonable attendance levels. Despite this nursing staff must have felt that once again a good opportunity was being missed.

During the 1970s, people with a learning disability fared little better than those suffering a mental disorder. Despite the introduction of *Better Services for the Mentally Handicapped*, the implementation of community care for this client group was slow and the targets were not achieved. The findings of Wistow (1988) and the report of the Audit Commission (1986a) noted that targets for the early 1990s were unlikely to have been met after the failure amongst agencies to agree exactly what community care meant for this client group during the decade that followed.

Over the course of the 1970s the number of long-stay learning disability patients in hospitals decreased but length of stay continued to be high (Hardy *et al* 1989). Increased death rates appeared to account for the reduced patient numbers and not an active policy of community discharge. The proposed reduction in the number of hospital beds in the larger hospitals was checked by the failure to create new, smaller more homely units because of a lack of specialist community staff. Local authority residential care did eventually begin to increase but, by the end of the 1970s, was more than 50% below targets set by *Better Services for the Mentally Handicapped* and the process was slowing down. DHSS reports in the late 1970s also reveal that standards in existing hospitals were far from satisfactory (Hardy *et al* 1989). As for joint planning, despite the creation of organisational mechanisms in 1974, lack of cooperation caused by fundamental differences in values and approach between the lead agencies was evident. All this led to the needs of people with a learning disability being inappropriately met, if at all, with resources being poorly utilised (Wistow 1988).

The Warnock Committee's Report, *Special Educational Needs* (1978) for children with learning disabilities provided important ammunition for the new campaign, Exodus, made up of the pressure groups, MIND, the Campaign for the Mentally Handicapped and others. Exodus was frustrated at the slow closure rate of hospital beds and it focused attention on getting children out of mental handicap hospitals and preventing their re-admission (Brown 1992). In 1981 the government brought in the '£ for £' scheme when it matched every £ raised for charity by voluntary effort for children with a learning disability. Two years later the Centrally Funded Initiative put over £10 million into getting children out of long-stay hospitals. This led to children with a learning disability moving out of hospitals at a much faster rate than adults.

In 1980 the Department of Health and Social Security's review of progress in care of people with a learning disability over the 1970s showed:

- hospital bed reduction had not been as rapid as planned
- children were the main group to benefit
- community provision had increased but not at a rate sufficient to compensate for the reduction in hospital beds
- expansion of community services had not occurred
- very few alternative models for locally based services had materialised (Brown 1992).

But there had been positive developments too:

- there was more emphasis on supporting families of children with a learning disability
- increasing appraisal of facilities was occurring to prevent the need for hospital admission
- multidisciplinary teams (medical specialist, nurse, psychologist, social worker, health visitor and possibly a teacher) were developing in hospital and community to provide a resource for carers of all people with a learning disability
- community mental handicap nursing was introduced as a distinct specialty
- the hospital developed as a resource centre offering day care and short-term placements, and also provided central facilities for satellite residential units
- attempts had been made to improve the quality of life of people likely to stay in hospital
- encouraging links were emerging between health authorities and local authorities through Joint Care Planning Teams and joint finance
- a growth in local initiatives attempting to integrate people with a learning disability into local communities using voluntary effort
- movement from a medical approach to social and educational patterns of care (Brown 1992).

The Jay report (*Report of the Committee of Enquiry into Mental Handicap Nursing and Care* 1979) made a clear and emphatic statement about settings and staffing. Its model of care was based on three principles: that people with a learning disability have a right to live normally in the community, that they have a right to be treated as individuals, and they need help from their communities and professional services if they are to reach their maximum potential (Brown 1992). These principles were transformed into policy actions that focused on normal, ordinary living, preserving individuality, and coordinated services that acknowledged a 'life plan' for everyone and advocacy schemes. These recommendations from Jay were to influence learning disability policy and provision throughout the 1980s.

But not everyone favours the closure of long-stay hospital places. Brown (1992) reminds us that relatives at Cranage Hospital in Cheshire formed the National Society for Mentally Handicapped People in Residential care (RESCARE) which became influential throughout north west England and nationally. RESCARE argues that the economies of scale and asylum for residents of large hospitals should be transformed into village communities of up to 1000 residents (Brown 1992). Village communities are popular in Holland (Churchill 1992). This view counters the prevailing ideal of normalisation which favours small dispersed units in ordinary housing and integration into the community. The King's Fund report, *An Ordinary Life* (King's Fund 1980), maintains that the cost of community units need be no greater than institutional care. But the Short Report, *Community Care: with special reference to adult mentally ill and mentally handicapped people* (Social Services Committee 1985) argued that community services often cost more than traditional hospitals. The campaigning group, Values into Action (formerly the Campaign for Mentally Handicapped People), and the Association for Residential Care resist strongly any reversal of the hospital closure policy and advocate more resources to community care so that it can work (Churchill 1992).

2.2.4 Approaches to care

A major development in the care of mentally ill people is the therapeutic community movement. Its origins can be traced back to Tuke, a Quaker, in 1792 (Chapman 1992). Chapman tells us that Tuke believed madness and deranged behaviour to stem from the mode of service provision in 18th century 'madhouses' where 'lunatics' suffered degradation, repression and cruelty. Scull (1979) wrote about care of mentally ill people before the 19th century as being a way of solving society's difficulty in knowing how to handle socially disadvantaged groups. Tuke replaced physical constraints with moral constraints based on reason and achieved through purposeful work and social and educational activities in a normal domestic environment. The 'moral therapists' challenged medical dominance in the treatment of 'the insane', arguing that medicine had abused care and medical treatment was unnecessary in moral therapy because carers were selected for their attitude and personality. The moralists considered the newly industrialised society to be the source of mental instability and cure could be found in calm, productive, non-competitive communities (Scull 1979).

The moral therapy movement lasted only 50 years in Britain (Chapman 1992). Chapman drew the following conclusion:

> 'The legacy of the failure was the large, overcrowded custodial "warehouse for the mad" which stressed bureaucratic organization of patients' lives and the rigid doctor, nurse, patient hierarchies found in asylums in the middle of the 20th century' (Chapman 1992: 325).

The era of the large mental and mental handicap hospital brought with it the dominant beliefs that: patients should be protected from society and society from them, that physical care and maintenance was the priority, that people with a learning disability were happier living with people 'of their own kind', and that hospital care would provide relief for parents and society. People with a learning disability were either a burden to be pitied and offered charity; or society had a responsibility to protect and care for them, in which case handicapped people and their families were expected to conform and be grateful because the professionals knew best. The result was a powerful, hierarchical model of care provision for users and staff that was couched in a strong Judeo-Christian belief that a mighty welfare system was right (Hughson & Brown 1992).

The principles of care developed in the USA of normalisation, integration and social role valorisation (Nirje 1969, Wolfensberger 1972, Wolfensberger & Glenn 1975) have influenced opinion leaders in the field of learning disabilities, particularly, since the 1960s. These developments provided a strong impetus for the de-institutionalisation movement, slow though that turned out to be. The normalisation movement, founded by Nirje and guided by Wolfensberger, has strongly influenced development of care approaches in the community (Nally & Steele 1992). O'Brien (1988) articulated the normalisation approach by specifying five principles of practice that service provision should promote: choice, respect, presence in the community, relationships and capability. This approach contradicted the traditional attitudes in society to people with handicaps that were based on pity, fear and hostility.

For community care to become a reality society has had to overcome three endemic problems. First, that disabled, elderly and mentally ill people do not contribute to a society that is steeped in materialism. Second, that the stigma and 'spoiled identity' attached to disabled people remains; they continue to be socially isolated through poverty, excluded from integrated employment, leisure activities and education, and segregated in their receipt of social services. Third, that carers are exploited and expected to provide care without help (Nally & Steele 1992).

Hughson and Brown (1992) provide a useful overview of the approaches to rehabilitation of people with a disability that have changed with the shift in values and practices. Rehabilitation models have moved from 'dependent models' (emphasising medical treatment, detention, sheltered care, parental-type control and trusteeship), through 'transition models' (focusing on instruction and counselling), to 'independent models' (of work, home and leisure). Service delivery models have also shifted, Hughson and Brown maintain, to reflect changing values:

- the 'welfare model': government policies and programmes provide rehabilitation services for people who meet the eligibility requirements
- the 'professional model': emerged from medical and educational foundations and operates on the same basis as the welfare model
- the 'self-help model': emphasises human dignity, social cooperation, mutual responsibility and mutual aid
- the 'social action model': encourages people to assert their right to support so that they can contribute fully to society
- the 'brokerage model': developed from the self-help and social action models and claims that people have the right to control their own lives within their own communities, including control of the resources they need.

Service brokerage/individual funding packages originated in Canada (Churchill 1992). The role taken by the professional in this model varies; it can be case manager, advocate, family supporter or coordinator of individual programme planning. The broker acts as an agent for people unable to speak for themselves and buys the services needed for that person. The purchasing power is vested in the individual (or broker) to buy from a range of services rather than to ask a statutory agency to provide on a 'take it or leave it' basis. Individuals are beginning to obtain 'individual funding packages' which they use to hire staff to meet their needs. There are legal, procedural and technical details to be navigated and individual packages are often channelled through a voluntary agency or trust fund to cope with this (Churchill 1992). Churchill doubts that the individual packages of care described in the government White Paper, Caring *for People: community care in the next decade and beyond* (Department of Health 1989a), will allow individual clients to control funds even though this is a logical step in creating a real market for care services. The brokerage model requires a major shift in the way of thinking of professionals so that they act in real partnership with service users. The role requires dedication, commitment and skill (Hughson & Brown 1992).

Self-advocacy is now beginning to replace the role of worker-advocates for people with a learning disability. Many people can make their own choices and decisions, and take responsibility for these, if allowed to do so (Hughson & Brown 1992). Since the 1970s, moves in the USA and the UK have been to introduce training programmes to support people with a learning disability to speak up for themselves. This approach requires professionals to become good listeners and work in partnerships so that power is truly shared. The activities of the People First movement in North America and the UK have emerged as a result of these initiatives.

An ideological divide? Social work and medical models of care

As the 1970s progressed the social work model of care for people suffering from either mental illness or learning disability became increasingly influential (Jones 1993). In contrast to psychiatrists' emphasis on diagnosis and physical treatments (particularly drug therapy) the social work model focuses on patients' social problems, emphasises family-centred working, advocates the development of interpersonal and counselling skills for professional carers and promotes alternative therapies. Mental illness is not seen as unique in its caring requirement, perhaps emphasised by the lack of specialist terminology to distinguish between sufferers.

The central theme of the social work model sees the technology as the self and the primary technique as one-to-one work (Pollock 1989). A semi-official inquiry by the National Institute of Social Work argued that all social work could be defined as permutations of counselling and social care planning. Thus, for most social workers of the time, skills were needed which focused on the individuality of the client. Counselling skills were drawn from a variety of models; models which conceptualised the client as rational and pragmatic and promoted the creation of coping strategies through discussion and an analysis of what the client was capable of. Behaviour modification and Freudian-derived psychotherapeutic techniques were also practised despite pressure to re-define the self and society (Aldridge 1994).

The drive within social work, as far as community care of the mentally ill is concerned, is for greater client autonomy and empowerment (Pollock 1989). Social work advocates holistic assessment through friendly discussion, assisting the client with the daily pursuit of purposeful activity and enabling clients and informal carers to express their needs (Pollock 1989). This was perhaps best achieved by creating a therapeutic relationship embodied in counselling techniques described by Rogers (1967), which emphasises the need for 'trust' and 'realism'. Thus, the professional carer would engage the client as an equal. Together they would develop strategies aimed at achieving as normal a lifestyle as possible (Rogers 1967, Wolfensberger 1970). Normalisation was the goal for people with mental illness and for people with a learning disability. The social work model called for users and carers to address housing, work and economic needs as priorities (Pollock 1989).

In parallel with the increasing influence of the social work model nurse education had also become aware of the need to address societal factors in community care (Salvage 1985). Community nursing of the mentally ill and learning disabled needed to consider social, economic and psychological factors as well as attend to health needs. The widespread use of the nursing process in the 1970s led to a more client-focused approach and both assessment and outcome evaluation gained prominence (Salvage 1985).

Even so, new nursing syllabi in the 1980s still ignored key issues such as the trauma of institutionalisation or the experience of mental impairment. Professional care was still marginalised in favour of attempts to achieve full clinical recovery (Salvage 1985). In its evidence to the review of mental health nursing the Royal College of Nursing concluded that nurse education had moved from training psychiatric nurse specialists towards a more generalist approach (RCN 1993).

The medical model within nursing was more resilient to change than the social work model. Although a gradual drift towards holism existed it manifested itself mainly in an appreciation of the changing role between nurse and client brought about by community care. Nurses were concerned about the effect on morale such changes might have and as late as 1988 the Standing Nursing and Midwifery Advisory Committee expressed concern about the status of the profession and the need for effective post-basic education and training (RCN 1993).

Social workers and nurses can disagree strongly on best care provision for people with a learning disability. Proponents of hospitals and the medical model are mostly nurses who say that there will always be some patients who require treatment that only hospitals can offer (Churchill 1992). The argument can therefore be logically confined to how large that group should be rather than whether people who are not ill should be in hospital. Social workers tend to reject hospitals as the right place for people with a learning disability but may see them as a last resort for people for whom a community placement cannot be found. This puts social workers into conflict between their professional ideals and using a service that they see as inappropriate (Churchill 1992).

By the beginning of the 1980s the new Conservative government was keen to sustain the move away from specialism towards community care embodied within the social work model. It agreed that pharmacotherapy offered the best hope for cure or restoration for people with mental illness or disability but was committed to reducing public expenditure. The policy of promoting supposedly less expensive community care instead of costly hospital provision, selling off public assets and encouraging other sectors of society to participate in a 'mixed economy' of care fitted well with the view that specialist services were inappropriate (Weller 1993). The generic approach to mental health care, it was argued, meant that a variety of services could be provided, many taking a more practical, less technical, approach and public expenditure could be minimised. This generic trend was a major concern for many mental health and learning disability nurses and remains a central issue for debate (Mangan 1992, Thomas 1993).

2.2.5 Reorganisations in the 1970s

The 1970s were dominated by legislation designed to restructure local and health authorities and determine new responsibilities in community and hospital based care. A new role was created for the social services following the Local Authority Social Services Act (1970) and a new national training body was created, the Central Council for Education and Training in Social Work (CCETSW). This was followed by a merger of the social work specialisms of child care, medical and psychiatric social work into the all embracing British Association of Social Workers.

Health authorities were restructured in 1974 to form regional and area bodies working alongside district management teams. Area health authorities became co-terminous with new local authority boundaries which should have helped coordination between the health and social services. Joint Care Planning teams were established but resourcing services remained a problem, especially as health and local government authorities were funded from different purses. Joint finance schemes introduced in 1977 were an attempt to solve these problems (Brown 1992).

The reorganised social services had moved away from specialising in psychiatric work and opted for a more generic approach. To some extent this was true of psychiatry and learning disability nursing services by virtue of their incorporation into medicine. But the responsibilities of social services departments and health authorities were now well defined and clearly different. Their way of working and their approach to care provision were also different. Patients experienced a medical or a social work model of care but rarely both and the two forms of service provision rapidly grew apart (Jones 1993).

2.3 THE QUICKENING PACE OF CHANGE

The need for change quickened in the 1980s. The Nodder Report (DHSS 1980b), for example, advocated changes in the organisation and management of mental hospitals and the need for professional collaboration in assessment, planning, treatment and rehabilitation became increasingly clear (Jacobson *et al* 1991). Changes in values with

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the widespread acceptance of normalisation theories and users' rights and involvement were evident. The emphasis now was on community care that provided a normal homely environment and opportunities to mix with the community at large. The role of medication was changing from control of symptoms to enhancing quality of life and allowing social integration (Jacobson *et al* 1991).

The DHSS circular *Health Service Development in Care in the Community and Joint Finance* (1983) highlighted the need for inter-agency collaboration on service provision and set up financial mechanisms so that this might take place. There was also recognition of the need to incorporate voluntary organisations, education and public housing services to provide a package of care to replace old-style hospital provision. By 1985 the government had received the *Select Committee Report on Community Care* (Social Services Committee of the House of Commons 1985) which had canvassed views from a large number of organisations and commentators. The Committee concluded that community care was patchy, community services were ill-equipped and a poor alternative to those being discharged from long-stay hospital wards and that joint health and social services finance strategies had not got off the ground. Ideological differences between health care professionals, allied to the lack of well defined guidelines for collaboration, were identified as major explanatory factors. The government's approach fared little better in the Audit Commission Report (1986a) which revealed confusion in joint financing because no one agency had lead responsibility.

In spite of these shortcomings, community care policy had begun to bear fruit. During the 1980s pockets of good practice were evident across the country and provided examples of what could be achieved and what should be aimed for in the future. In the areas of housing, domiciliary care, day care and employment and training, new community services emerged which promoted some of the espoused goals of the New Right: greater efficiency and value for money, reduced bureaucracy allowing greater user involvement, greater choice and more flexible use of resources (Department of Health 1989a).

The DHSS review *Mental Handicap: progress, problems and priorities* (1980a), established targets for reducing numbers in the NHS and encouraged a joint strategy of community placement. This strategy was supported by the 1983 DHSS circular on joint planning (DHSS 1983) which described the financial mechanism for transferring finance from the NHS to the local authorities and the independent sector; an initiative reaffirmed by the Select Committee Report in 1985 (Social Services Committee of the House of Commons 1985). Later publications, in particular the Audit Commission report (1986b) and the Griffiths Report (Griffiths 1988), illustrated the underlying politico-economic

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changes in the welfare state since 1971 (CCETSW 1992). Changes in care approaches were reflected in *Caring for People* (Department of Health 1989a) and the NHS & Community Care Act (1990) both of which examined radical alternatives to community care and again cited examples of good practice.

Many initiatives have taken place in the last decade which have had an impact on the lives of people with mental illness; for example in the areas of employment and residential provision (e.g. Pattie & Moxon 1992, Gatula & Morris 1993) and services related to home support (e.g. Mason 1994). There have also been examples of innovation designed to help give people suffering from mental illness and learning disability and their informal carers the opportunity to articulate the kinds of services they would like to receive; for example, advocacy services (e.g. Evans 1994) and user consultation (Warner 1993). Amongst many other examples of innovative community services are those to assist transient populations (e.g. Gaulton-Berks 1994), train informal carers in the care of their dementing relatives (Arsden 1993) and assess the mental health problems of those coming into police custody and expedite a suitable form of detention (George 1993).

Similarly, there have been examples of good provision for people with learning disabilities which have evolved since the early 1980s including the creation of community mental handicap teams to advise staff, clients and carers on local residential provision and day care to help link services with voluntary organisations; community units to act as a first point of contact for observation; assessment and provision of education and training (see Allen *et al* 1991), and MENCAP's Gateway Clubs which provide daytime and leisure facilities for people over 16.

In the learning disability field, the reforms of the last 10-15 years have emphasised creating services to meet the needs of those with severe handicaps and challenging behaviour, a group of people who present special difficulties for themselves and their carers. A report by The Kings Fund (Allen *et al* 1991) cites a number of examples of this kind of provision.

2.3.1 Influence of the independent sector

The 'independent sector' consists of any service provision outside the statutory health authorities and local authorities and so includes the private and voluntary sectors (housing associations, charities, voluntary agencies, not-for-profit organisations). The independent sector has increased enormously. Many local authorities transferred management of their residential homes to the voluntary sector whilst retaining ownership

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(Churchill 1992). The management agency had access to central government funds and the local authority negotiated a contract and retained the statutory obligation to inspect and maintain standards. Voluntary bodies are also regulated by external agencies; registered charities by the Charity Commission, limited liability companies by the Registrar of Companies and Company Law, housing associations by the Housing Corporation, and not-for-profit organisations by the Registrar of Friendly Societies and the Registrar of Industrial and Provident Societies.

The private sector - owner occupiers of residential homes - has proliferated, often with fees well above the national minimum (Churchill 1992). As Churchill observes, private homes that cater for 'difficult to place people' who display 'challenging behaviour', who would have been placed in hospital, are increasing. The temptation to go for economies of scale and return to the large, inflexible 'total institution' is not always easy for the private sector to resist.

The consortium is another organisational structure to gain popularity. Statutory and voluntary bodies have joined forces to manage residential and day care provision and to cope with financial pressures (Churchill 1992). The consortium might be made up of participants from the local authority, the social services department, the health authority, the housing association and, possibly, voluntary organisations. Churchill identifies advantages of consortia as:

- maximising resources from central government (although not after April 1993 when income support disappeared) and other agencies
- encouraging agencies to work cooperatively not competitively
- contributing significantly to meeting the housing needs of vulnerable groups.

But there are also disadvantages to consortia:

- confusion over responsibilities is common
- they are only as strong as their weakest link
- they are difficult to construct and maintain
- they need careful planning at operational level (Churchill 1992).

The approach to care found mainly in the voluntary sector and in some private homes follows the current mainstream philosophy of normalisation. But other approaches exist, many of which overlap with normalisation strategies (Churchill 1992):

- L'Arche Communities: Christian based, encourage handicapped and non-handicapped people to live and work together, and the handicapped to move on to other accommodation when they are ready.

- Camphill Communities: follow the 'anthroposophism' philosophy of the Steiner educational ideas to develop therapeutic communities. Handicapped and non-handicapped people live together in mutual respect and no-one is a paid worker.
- CARE (Cottage and Rural Enterprises) and Home Farm Trust: are organisations that aim to provide a stable environment in homes of 30 - 50 broken down into domestic sized units. This style of living is supported by parents who want a safe, secure and permanent place for their children with a learning disability. The environment provides horticultural and agricultural employment. There is a move now to develop smaller houses in local communities.

The 1980s saw a residential home boom in the private sector whilst the voluntary sector increased slowly and the statutory sector contracted. During this time there was more or less unlimited access to residential care because of the statutory supplementary benefit system which gave clients access to state funding as of right by virtue of their handicap. But controls were imposed in 1986 and tightened further in 1987, after which financially accessible residential places became more difficult to find (Churchill 1992). The boom in private residential care came to an end as small homes were unable to run on income support and local authorities were finding it increasingly difficult to top up residential grants.

The White Paper, *Caring for People* (Department of Health 1989a), published in response to the Griffiths proposals on community care (Griffiths 1988), led to local authorities taking responsibility for monitoring community services and contracting them out rather than being a monopoly provider. Therefore the role of the independent sector has increased. Access to services is made through assessment by local social services departments of clients' individual needs and local authorities fund individual packages of care until the money runs out. There is thus no longer any incentive for local authorities to place someone in private residential care.

2.3.2 Organisational reforms in the 1980s

Ever since the 1974 NHS reorganisation there had been debate about which of the excessive number of administrative tiers - regional or area health authorities - should go (Brown 1992). In 1982 it was the area health authorities that disappeared in another reorganisation. District management teams were developed in district health authorities which meant that the co-terminosity set up between area health authorities and local government boundaries - intended to promote coordination of services - was lost.

Brown reminds us that the 1983 Griffiths Report on the management of the NHS raised doubts about the effectiveness of consensus management introduced in the 1974 reorganisation. Instead Griffiths recommended a general management function. Managers on short-term contracts were to be held accountable for their performance and, in areas where their performance was measured by a reduction in the number of hospital beds, community care in the long-stay sector was boosted. But transferring residents from hospital to community care continued to be difficult because of the end of co-terminosity between health authorities and local authorities and lack of sufficient funds for community care from central government (Brown 1992). Health authority managers resolved this by bypassing local authorities and transferring residents to the private sector.

The Audit Commission report, *Making a Reality of Community Care* (1986a), called for radical steps to solve problems underlying community based services: distribution of finance was not balanced and was out of step with community care policies; there was organisational fragmentation and confusion; training for staff who were transferring from traditional hospitals to the community was inadequate; progress to community care was slow and inadequate; and the number of nurses working in psychiatric and mental handicap hospitals had *increased* even though the patient population had fallen (Nally & Steele 1992).

In December 1986, the Secretary of State for Social Services, Norman Fowler, asked Roy Griffiths to review the way public funds were being used to support community care policy and to advise on action needed to improve community care provision. *Community Care: an agenda for action* (Griffiths 1988) highlighted a gap between rhetoric and policy and between policy and its implementation on the ground, and demonstrated the need for some legislative framework for the community care of mentally ill people and those with a learning disability. The cornerstones of the proposals were to further stimulate the need for a mixed economy and encourage local authorities to become arrangers of care rather than monopolistic providers. Health authorities were still to have a key role in the interaction of acute and community services but with less emphasis on long-stay provision, and proper assessment of handicap was essential. Assessment of user need and care management together with the purchasing and provision of services to enable people to remain at home were at the heart of the proposals. For Griffiths the role of the public sector was to ensure that proper mental health care be provided. How this was done was less clear although high quality care promoted by competitive provision was emphasised.

Nally and Steele (1992) observe that the later Audit Commission report, *Developing Community Care for Adults with a Mental Handicap* (1989) continued to be critical of the lack of progress in community care. Sixty percent of local authorities had not reached agreement with health authorities on financial and practical arrangements for resettling residents. Half the funds were still tied up in hospital provision leaving users inadequately supported in the community, particularly in respite and day care facilities. The rapid, unplanned expansion in residential provision in the private sector because of the availability of social security benefits was heavily criticised. That money should have been available for supporting family carers.

At the same time the White Paper, *Working for Patients* (Department of Health 1989c) was published. It outlined a strategy for provision of better health services, greater choice and greater flexibility of services by regional, district and family practitioner bodies. By the end of the 1980s it was apparent that, although health care professionals had taken on board the spirit of community care, standards varied across the country and coordination of services was deficient (Weller 1989, Campbell *et al* 1990).

Government reaction was slow but it eventually accepted the 1988 Griffiths Report and produced legislative framework in its 1989 White Paper, *Caring for People: community care in the next decade and beyond*. This White Paper led to the NHS & Community Care Act (1990). *Caring for People* set a clear agenda for the 1990s in suggesting the need for a market approach to care provision and new management techniques necessary to achieve this. Mechanisms to promote choice and flexibility, matching services with needs and promoting accountability and quality control were described and further taken up by the Act. The new language of case, or care, management, the purchaser-provider split and contracting underlined the importance of consumer choice and control and improved standards.

There were some voices of caution however. Wing (1990) protested that the new ideas in community care should not ignore the literal meaning of asylum, particularly for people with severe mental health problems and challenging behaviour. The new financial arrangements for transferring monies to local authorities from income support were also of concern. The fear was that some authorities would be discouraged from using existing housing stock, under the new arrangements, in favour of placing people with the independent sector. The long-term emphasis for local authorities might then be greater provision of domiciliary care rather than residential or nursing home care for people needing 24-hour care.

2.4 PRESENT CONCERNS

The 1990s have witnessed many changes in community care policy. The move to transfer hospitals to NHS trust status has had far reaching effects in terms of management approach. Similarly, the purchaser-provider split has caused local authorities and health authorities, NHS trusts and GPs radically to rethink their role. The emphasis today is on community care with an internal market perspective. Lawson (1991) sees the catalyst for change within the government as the desire to eradicate inefficiency and poor value for money. The Left of the Conservative government wished to address the perceived lack of equity and social justice in the existing system (Le Grand 1989, 1990). The outcome is a 'social market of care' (Lawson 1991) or quasi-market; a cross between traditional free market principles and state controlled services because it lacks private sector sellers, does not have a profit motive, involves third parties as case, or care, managers and uses not only cash as the means of exchange (Le Grand 1990).

It was envisaged that the social market would bring about greater choice. Competition amongst providers would increase cost effective services for the community. With the state primarily fulfilling the role of purchaser with minimal provider functions, the scope for monitoring and evaluating quality would be enhanced. In the private sector, the government hoped that companies would be linked more closely to their communities thereby promoting social justice in care.

It was expected that the market approach would have a direct effect on community nursing. With NHS trust hospitals promoting the need for client choice in an age of consumerism and greater freedom in purchasing, nurses are having to re-examine their relationship with patients (Griffiths 1988, Department of Health 1990a). They no longer orchestrate the care needed but work in cooperation with users to produce packages of care based on expressed need. Current wisdom suggests that this role can best be performed when nurses act as care or case managers (Onyett 1992). Within community teams they have operated well as key workers (Intagliata 1982, Test & Stein 1980), but there is a need for nurses to advocate on behalf of users in terms of their total needs. Some caution has been voiced however. Sandford and Gournay (1994), in calling for assertive care management, note that the nursing advocacy role can only be achieved through careful handling of the role played by users. User involvement is just one issue, another is the degree of direct care provided by care managers. Case management has been defined in a number of ways but will undoubtedly play an important role in the future care of people with serious mental health problems (Sandford & Gournay 1994).

Amongst a number of challenges facing nurses in the community is the need to re-define their role in terms of support staff. As increasing numbers of support workers are engaged to perform basic tasks, particularly in residential settings and, as their status increases through possession of NVQ qualifications, nurses must address the need to provide adequate training, support and supervision. The involvement of primary services is another key issue. Whether by way of attachment to community practices or just through closer contact, nurses are being required to act as advisers on first contact with people with psychiatric symptoms or indicators of a learning difficulty. The issue of shared training is now receiving high profile in some quarters (see Chapter 3). Many purchasers are calling for education to produce health care workers capable of dealing with any situation and meeting the total needs of users. Mental health and learning disability nurses have to decide if they wish to retain their specialist identity or adapt to a more generic approach to community care.

How then has the market fared thus far? Bosanquet (1993) argues that, in general, the changes have been good but badly publicised. Had the reforms been seen from the start as a means of decentralising public expenditure then perceptions may have been different. In contrast to this view there are still perceived dangers in the new system (Donaldson & Mooney 1993). Competition to demonstrate quality and efficiency may lead to expenditure being incurred on ineffective diagnostic equipment, for example, in order to look good and thereby diverting cash away from direct services and ultimately patient care (Donaldson & Mooney 1993). Moreover, in some areas monopolies may exist which may mean that the change from health authority control to internal market provision is not that discernible. Indeed, monopolies of provision may be detrimental with less social control and the overriding desire to reduce expenditure. Furthermore, information for decision making sounds good in principle but the effect may be to employ more administrative and managerial staff to decipher the information. The question then is whether the cost of administrative and managerial support should outweigh expenditure on resources.

Ham and Maynard (1994) argue that the way forward is for NHS management to have greater freedom and for government to oversee but not control. They see the core principles of such as open information, control of labour and capital markets, regulation of mergers, arbitration of disputes, protection of non-profit making functions, overseeing health care provision, protecting basic NHS principles and dealing with closures and redundancies. They argue against intervention and for the NHS Executive to act in a watchdog role working with '....health authority purchasers operating within a framework set by politicians' (Ham & Maynard 1994:847).

The debate on community care has recently switched to the need for secure provision and asylum for those who need or desire it and for the community. The cases of Beverley Allitt, Christopher Clunis and others more recently have strengthened this argument (Burrow 1993). The call now is for properly augmented policy on secure provision when justified but within a broader mental health context. Pressure groups, like SANE, are reporting substantial numbers of people having been discharged into the community from psychiatric hospitals since the 1959 Mental Health Act. Though closure of the large hospitals is still widely supported this policy puts pressure on providing asylum for those who need it. The lack of adequate facilities is worrying.

2.5 CONCLUSION

It has been the policy thrust of successive governments for over 30 years to reorientate mental health service provision away from institutions toward community settings (DHSS 1975, 1980a). This chapter has sketched the history of these developments from the 1960s to the NHS & Community Care Act (1990) and reflects upon its effect. It is against this background of service provision that our study is set.

The premium given by *Caring for People* (Department of Health 1989a) to widen user choice and the power of consumer pressure on provision of services in the 'market place' is often not realised. A person's freedom to choose may not match a local social services department's preferred pattern of service provision with the result that professional advisers may find themselves having to 'persuade' their clients to choose 'appropriately'. As Churchill (1992: 37) observes, '[m]aking a reality of client choice and client access will present a challenge to all future professionals - providers and advisers alike.'

Churchill predicts that the voluntary and private sectors will increase. Also that the local authority role will diminish to a monitoring and purchasing function together with staffing and running some residential services. The range of voluntary services will widen as local authorities encourage them to increase day services, domiciliary care, information services and so on. Therefore, Churchill suggests, the voluntary sector may become more like the statutory services used to be and they may lose their unique roles of advocacy and campaigning.

A most significant change is the introduction of the contract culture. Providers are having to become more flexible to meet individual needs. New, smaller, localised services will increase. There is a clear role for the professional (nurse or social worker) to take the lead in defining objectives, planning care and delivering new types of service.

Pressure is increasing for smaller residential units even though they may be grouped together to be viable 'care homes'. The danger will be if severe limitations in funding leads to standardisation of these units and loss of flexibility.

Although mental health and learning disability nurses have contributed to the development of innovative community services, what is more striking is that they were almost ignored in the early planning of community care and they exercised only limited influence in the course of reforms. Nurses were to a great extent left to look after large groups of long-term people in hospital who, it was thought, could not survive in the community. This lack of influence by nurses reflects the relatively minor impression nursing has made compared to other health care professionals; a consequence perhaps of nursing's close alliance with psychiatry. Although the influence of psychiatrists remains great, they have lost ground to health service managers and to other professional groups, particularly social workers, who were recruited in great numbers in the 1970s, and clinical psychologists whose numbers increased tenfold in in-patient and out-patient units between 1965-75 (Busfield 1986).

The move away from a hospital based to a community based mental health and learning disability service broke the historical link between 'patients' and doctors and nurses, and the history of community care suggests that nurses were slow to understand this and to respond. Community based services ushered in a different set of professionals operating to a new set of principles allied to a social work rather than a psychiatric model of mental health care. The social work model incorporates a generic orientation. It has been fostered by the Conservative government concerned to cut costs and promote value for money. It has been spurred on by their internal health care reforms which have forced health and social care providers to undertake skill-mix reviews to provide a flexible, low cost workforce. The extent to which the educational preparation of nurses has been proactive or has responded to these service developments is the issue to which we now turn.

CHAPTER 3
EDUCATIONAL DEVELOPMENTS

In Chapter 2 we charted the progress of community care policy and practice from the 1960s up to implementation of the NHS & Community Care Act (1990). Against this backdrop we turn now to consider developments in the education of mental health and learning disability nurses. We look at the influence of major initiatives in nursing education on the two specialties; in-particular, Project 2000 (UKCC 1986) and the development of training for support workers. The literature reveals parallels between the education of social workers and of nurses in learning disability and some comparisons and contrasts are drawn. Our observations accord with conclusions in Chapter 2 concerning the decline in influence of the medical model on nurses' education in favour of the social work model advocated by social workers, occupational therapists and some clinical psychologists.

3.1 CHANGING EMPHASES IN TRAINING

During the 1950s and 1960s mental health nurse training was characterised by the need to maintain the function of the large institution (Nolan 1993). Tutors taught the technical aspects of nursing and did not visit students during their hospital placements. Students were not required to evaluate the prevailing practice and tended, therefore, to copy what they observed. Consequently there was no formal training in the art of forming and sustaining therapeutic relationships with patients (Martin 1968) and the curriculum reinforced the nurse's role as doctor's assistant. Pre-registration education was based on a small number of textbooks which gave nurses a simplified version of the principles and practice of psychiatry. Nursing components emphasised practical procedures and management of patients within the hospital setting.

Although mental health and learning disability nurses and nursing had been the objects of social research in the 1950s and 1960s (Oppenheim & Ereman 1955, Menzies 1960, John 1961, Moore 1961), it was not until the late 1960s and 70s that nurses themselves began to analyse and evaluate their practice through published research. The workforce was plagued by poor skills in developing interpersonal relationships and a lack of theoretical understanding of the specialist needs of these client groups (Altschul 1972, Towell 1975, Cormack 1976, Clinton 1981, Pollock 1982, 1989). Many researchers found that nursing education was still entrenched in ideas about the institution, producing nurses who continued to seek protection from the organisation and its practices and avoid innovative care programmes.

Thomas (1992) summarises curriculum developments in psychiatric nursing. He notes that the 1952 General Nursing Council (GNC) psychiatric nursing syllabus reflected the view that psychiatric was very similar to general nursing. Anatomy and physiology featured strongly, psychiatric topics not being covered until the final year. In 1957 an experimental syllabus was introduced based on the concept of 'situation-centred teaching' which emphasised that subjects taught, which now included psychology and psychiatry in the first year, should be applicable to direct patient care. This approach to teaching was endorsed in the 1964 GNC psychiatric nursing syllabus which comprised three areas of study: the human individual; concepts of mental disorder; and skills needed to deal with mental disorder - preparation of patients for procedures and investigations, administering drugs and monitoring their effects. A substantial amount of the syllabus continued to focus on human biology, psychophysical disturbance, physical illness and first aid.

A major review of psychiatric nursing by the then Ministry of Health (1968) focused particularly on in-patient psychiatric nursing. Amongst other recommendations this report identified the need for psychiatric nurses to develop skills in psychotherapy, a view which resonated with views of opinion leaders of the time, such as Altschul who had endorsed interpersonal skill development several years previously (Altschul 1964). Ten years later Harries (1978) points out that many nurses had developed such skills experientially mainly in those services which had evolved as therapeutic communities.

The 1974 psychiatric nursing syllabus continued along the same lines as the 1964 syllabus, but for the first time introduced sociological concepts and community care and gave more attention to services such as occupational, recreational and industrial therapy. It also advocated increased specialised teaching from doctors, social workers and those from other therapy professions. Speight (1978) argues that this syllabus reflects some of the training requirements of EEC directives by including sociology and by requiring rather than recommending (as in 1964) that the student nurse gain a minimum of four weeks' community experience. Also, in keeping with EEC directives, the GNC advised that 12 weeks' training in medical and surgical wards be included in the training programme.

During the 1980s, which were characterised by cutbacks in NHS spending and changes in the law concerning people with mental health problems, a new emphasis was placed on nurse training. The Judge Report on nurse education stated the need to better educate and widen the knowledge base of nurses by improving links between schools of nursing and hospitals (Royal College of Nursing 1985). The report highlighted the need for students to be treated as learners and not used as a cheap labour force, and argued for teaching both concepts and practice of care. It did not, though, specify how this balance should be

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achieved nor how to support newly trained nurses in practice, how to teach nurses basic management skills, how to avoid duplication of effort between professions and how to cope with inter-professional rivalry.

Although the education debate was looking at ways of meeting community needs and raising nurses' morale, nursing academics and the Psychiatric Nurses' Association were protesting against the move towards the generic practitioner (Mangan 1992, Thomas 1993). What followed were revised nursing syllabi for psychiatric and learning disability nurse education in England and Wales (ENB 1982, 1983) which appeared at a time when the view that institutional psychiatric care was a thing of the past and community care its natural replacement went unchallenged (Weller 1989).

It is difficult to piece together the many influences on mental health and learning disability nurse education in the late 1970s and early 1980s when new syllabi were introduced. Opinion leaders have speculated that these developments originate in the philosophical debates and 'cultural revolution' of the 1960s and 70s some aspects of which we raised in Chapter 2. In particular the anti-psychiatry movement, perhaps especially the work of Laing whose writings caught the public imagination, the history of abuse in institutions, and the impact of therapeutic communities each of which shaped our thinking about mental health and learning disability care.

3.1.1 Mental health nurse education

In the following paragraphs we focus on the development of experiential learning and touch briefly on the influence of Peplau on psychiatric nursing education. A comprehensive analysis that captures the range and complexity of the issues which contribute to the historical context of educational developments is beyond the scope of this review.

A striking development in nurse education in the UK during the 1980s was the growing popularity of experiential learning. This is defined as learning which facilitates 'personal' knowledge gained through direct encounter with a person, place or thing, and which cannot easily be transmitted to other people (Burnard 1989). Burnard differentiates personal knowledge from 'propositional' knowledge (textbook knowledge concerned with facts and theories) and 'practical' knowledge (knowledge revealed through practice) which are emphasised in traditional learning methods in nurse education. Burnard found nurse tutors to be uncertain about what constitutes experiential learning and they used the term in different ways. They generally agreed, though, that experiential learning is concerned with personal experience and with practice rather than theory (Burnard 1989).

Experiential learning was already well developed in a few schools of psychiatric and learning disability nursing by the late 1970s and was developing in others. For example, the Maudsley Hospital School of Nursing (Dietrich 1978) concentrated on student-centred rather than teacher-centred learning and the personal experience of the student was the starting point for enquiry and reflection. However, the impact of experiential learning on nurse education owes much to Burnard's work, who made it a subject of academic study for nurses and popularised it through a prolific output in the nursing literature. It is also true that psychiatric and learning disability nurse tutors were a willing and ready audience for these ideas. Some tutors, Burnard tells us, underpinned experiential learning with theories about the person drawn from humanistic or transpersonal psychology. A new generation of psychiatric nurse tutors were talking about the need for personal growth as a prerequisite for skilled nursing intervention (Burnard 1986, 1989).

These ideas drew on humanistic theory developed by Rogers (1967) and the encounter movement and reached a peak in the 1960s. As Rogers (1985) points out humanistic psychology had relatively little impact on traditional academic psychology and yet mental health and learning disability nurse education in the 1980s was a fertile ground for these ideas to take root. Young nurse tutors of the 1960s, Burnard (1989) speculates, transferred aspects of the 1960s counterculture to the nursing syllabus and continued to hold these ideas as they gained seniority within the profession. It was teachers with this background in humanistic psychology who were influential in formulating the 1982 syllabus of training for psychiatric nursing students (ENB 1982). This syllabus recommended experiential learning methods. It was influential in nurse education beyond psychiatric nursing.

The 1982 psychiatric nursing syllabus emphasised nursing skills and had a very different emphasis than the 1974 syllabus which was essentially a list of content to be covered during the course. According to Thomas (1992) the skills emphasis was prompted by a desire of the authors to: define the skills of the psychiatric nurse; to highlight self-awareness as a prerequisite of all therapeutic interventions; and to stamp psychiatric nursing as a 'human activity'. We take human activity to mean that psychiatric nurses seek to help clients through the medium of a therapeutic relationship. Section 2 of the 1982 syllabus contains a list of knowledge to be covered during training and is similar to the 1974 syllabus.

Mindful of the need to persuade purchasers to consider non-mandatory courses in psychiatric nursing, the ENB recommended changes to the 1982 RMN course (ENB 1985) and, in 1988, commissioned a specialist panel to review curricula for inclusion of therapeutic intervention techniques so that the product of the course would be a specialist practitioner able to work collaboratively and autonomously (ENB 1989b).

Although the aim of the 1982 syllabus was fairly conventional in seeking to produce a competent nurse it represented a break with the past in its emphasis on students acquiring self-directed competence as a foundation for their professional career. Students were to be helped to identify their own learning objectives, how they might achieve these and also be involved in assessing their own competence. The syllabus emphasised andragogy, a term also associated with Knowles (1978), to differentiate the principles and practice of adult education from pedagogy, the principles and practice of educating children. Principles of andragogy include: grounding education in students' prior experience; providing opportunities for students to apply what they learn; and promoting active rather than passive learning. These principles resonate with those of experiential learning which also emphasises the importance of teachers (facilitators) drawing on personal experience of students and their subjective interpretation. These principles might apply equally to the education of children too, a criticism acknowledged by Knowles who, in later writing, describes andragogy as an attitude towards rather than a theory of education (Burnard 1989).

In moving from a teacher-centred to a student-centred curriculum nurse education reflects changes in adult education more generally. Jarvis (1995) argues that adult education has mirrored the developments in school education since the 1960s moving from the ideology of the 'classical' towards the 'romantic' curriculum. As described by Lawton (1973) the classical curriculum is subject-centred and emphasises skills, instruction, information, obedience, conformity and discipline. In contrast the romantic curriculum is child (student)-centred and emphasises creativity, experience, discovery, awareness, originality and freedom.

We see the emphasis in the 1982 psychiatric nursing syllabus on transpersonal psychology and nursing as a human activity as influenced markedly by Peplau. Peplau drew on Sullivan's (1953) theory of interpersonal relations to highlight psychiatric nursing as a therapeutic and interpersonal process in which nurse and patient are active partners in a mutual learning experience. Peplau was a major influence on psychiatric nursing in the USA through publication of her *Interpersonal Relations in Nursing* in 1952, further writings and her contribution to graduate psychiatric nurse education at Columbia and Rutgers Universities. However, her ideas were to enter psychiatric nursing education in the UK only slowly and it was the late 1970s and 1980s before they became prominent.

Peplau's emphasis on partnership between nurses and people who use mental health services has been reflected in the national review of psychiatric nursing (Department of Health 1994) that reported during the course of this study. The starting point of the review was the right of people who use mental health services to receive skilled, sensitive, professional support from competent mental health nurses. The deliberations of the review team covered a wide range of topics including: past problems and failings of the service, discrimination against women and people from black and other ethnic minorities, information for service users and carers, personal dignity, advocacy and individual accountability of nurses. The review considered clinical issues (including medication, restraint, seclusion, the use of locked doors, time out and record keeping), and challenges facing mental health nurses concerned with the relationship between mental health and gender, homelessness and rootlessness, sexuality and HIV and AIDS. The review made 42 recommendations many of which resonate with the views of respondents interviewed in the course of the present study which are described in Chapters 5 and 6.

3.1.2 Learning disability nurse education

Changes in learning disability nurse training since the early 1970s have somewhat mirrored mental health nurse training. Revised syllabuses have been developed at similar times to meet the changing needs of an increasingly community based service and perceived threats to the specialism in caring for this client group. Tierney (1983) argues that, since the formation of the NHS in 1948, nurses have challenged their role in respect of the mentally handicapped, particularly in its links to general nursing. The General Nursing Council devised a new syllabus in 1957 (1964 in Scotland) and again in 1970 (1972 in Scotland). The changes reflected a need for specialist training with particular reference to the physical needs of service users (Tierney 1983).

Tierney suggests that an aggravating factor, in terms of staff morale, in the early 1970s was the prolific use of unqualified staff in mental handicap hospitals. In 1979 in Scotland only 36% of learning disability staff in hospitals were nurses (i.e. qualified). Major reviews such as the Briggs Report (Report of the Committee on Nursing 1972) and the Jay Report (Report of the Committee of Enquiry into Mental Handicap Nursing and Care 1979) concluded there was little need for a specialty of nursing for the mentally handicapped. The question was whether learning disability nursing is a health (therefore nursing) or a social (therefore social work) occupation.

The Jay Report presented a series of principles based on the insights of normalisation and remains one of the most succinct summaries of the philosophical and moral initiatives that inform much current debate about service provision. These principles received widespread support but nurses took exception to Jay's proposal that staff be transferred to local authority responsibility and that the Central Council for Education and Training in Social Work (CCETSW) should become responsible for training care workers for people with learning disabilities living in residential homes. This recommendation met with such opposition from the nursing profession and the trades unions that it was rejected by the Secretary of State.

The GNC began critically examining the content of the learning disability nursing syllabus in order to deflect some of the implications of the Jay Report. A team of experts that explicitly excluded representatives of the Royal College of Psychiatrists, with whom previous liaison had been prominent, developed a new syllabus and identity. In 1982 the ENB introduced a new syllabus (ENB 1983) that departed radically from previous training in its emphasis on the principles of normalisation and on working in community and domiciliary settings rather than in hospital. It emphasised the importance of interpersonal skills employed outside institutional care, promoting self help and maintaining care in a home-like environment. The new vocabulary included 'the therapeutic relationship', 'therapeutic environment' and 'therapeutic process'. Learning disability nurses no longer regarded themselves as peripheral but as central to the new social work model of community care.

The Jay Report also stimulated the first initial steps towards joint and shared training between social work and learning disability nursing (Elliott-Cannon & Harbinson 1995). Comparisons are drawn between learning disability and social worker education in Section 3.4.

More recent reports have described learning disability nurses as indeed possessing specialist skills. *Caring for People* argues that these nurses have, as part of their core training, skills in nursing assessment and treatment, counselling for care, communication, behavioural change, research, community and family intervention and physical nursing (Department of Health 1989a). *Caring for People* acknowledges the need for specialist training so that practitioners can advise other workers, and states that nurses able to identify aggravated mental handicaps and psychiatric conditions helped the process of holistic care planning. As the report stipulates: these nurses need to be equipped to make good care managers in that specialist knowledge ensures skilled assessment, effective focused rehabilitation work, prompt identification of ill health and more aggressive treatment of treatable conditions (Department of Health 1989a).

There is now deep concern about the recent reduction in numbers of students being funded in all branches of nursing but most notably in learning disability (Elliott-Cannon & Harbinson 1995). These concerns led to the Consensus Conference, commissioned by the Chief Nursing Officer of England in 1992, which recommended that learning disability nurse training be offered at post-registration level although the learning disability element of the CFP of the DipHE should also be increased. These proposals provoked widespread criticism. Response by the profession to the statement put out by the Consensus Conference rejected the proposals and recommended continuation of pre-registration training in learning disability nursing within the 'family of nursing' while also recognising the value of shared learning and inter-professional working (Brown 1994).

In response to the resurfacing of old anxieties by nurses that learning disabilities would be removed from pre-registration training, the Department of Health made a commitment to maintain specialist training and in 1993 commissioned a small project team to identify the specific contribution of the nurse to the support and care of people with a learning disability. This project, which reported during the course of the present study emphasised the work of the learning disability nurse in eight key areas some of which resonate with the views of respondents interviewed in the present study (described in Chapters 5 and 6). The eight key areas are:

- assessment of need
- health surveillance and health promotion
- developing personal competence
- using enhanced therapeutic skills
- managing and leading teams of staff
- enhancing the quality of support
- enablement and empowerment; and
- coordinating services.

(Kay *et al* 1995: 18-35)

Brown (1997) comments that this newly defined role has diffused to some extent the debate as to whether nurses or social workers are best suited to learning disability care. The question now is not who has specialist skills, but rather whether the case for specialist skills is accepted by those responsible for providing services within the new internal market for health and social care.

3.1.3 Post-basic education

Although some post-basic training existed, the 1980s were to see a marked increase, with courses now to be validated by the National Boards. This led to nursing schools creating senior tutor posts to coordinate post-basic education district-wide. Finance was continually being restricted and NHS management changes had led to greater emphasis on educational evaluation, but service providers were demanding post-basic training opportunities for nurses.

The recent policy developments in post-basic education stem from the UKCC's proposals for post-registration education and practice (PREP), designed to produce specialist nurses and advanced practitioners, and the incorporation of Project 2000 into the higher award scheme (UKCC 1990, 1994). To achieve the desired status, both developments have been targeted for the Credit Accumulation and Transfer Scheme (CATS) developed by the Council for National Academic Awards (CNAA) (Reed & Procter 1993). The CNAA has now been taken over by the Open University.

The aim of CATS is to award credit at various levels of learning through a points system and it fits well within a modular programme. Minimum target points are required at each level of training before going onto a higher one and previous experience can be credited through the Accreditation of Prior Learning (APL) and Accreditation of Prior Experiential Learning (APEL) schemes.

If the DipHE is seen as based on more generic principles, post-basic training promotes specialisation. Shared and joint training seek to find commonalties in care and work towards the seamless service so much desired. The achievement of higher awards can be seen to be beneficial not only for practice but for status, morale and career development. The Higher Award for Continuing Professional Education, introduced by the ENB in 1992, is open to any registered nurse. It is seen as reaching the minimum level for a first degree and incorporates CATS so that nurses can gain credit towards more advanced awards (Elliott-Cannon & Harbinson 1995).

A range of post-registration courses is available to mental health and learning disability nurses. Aside from those validated by the statutory training bodies many are provided by higher education institutions or specialist voluntary bodies and many of these contain elements of joint training with other health care professionals.

Shuttleworth (1994) has argued that, although teething troubles may still lie ahead, the broad principles of continuing education in nursing, as laid down by PREP, are now well understood and approved. However, Canning (1994) sees funding as a stumbling block and clinical experience suggests that many nurses, who have always depended on their employers to provide post-basic education, may find it difficult to accept the fundamental change in philosophy which puts more responsibility on individual nurses to develop themselves professionally.

3.1.4 Community nurse education

In the early 1970s, and particularly following the White Paper, *Better Services for the Mentally Ill* (DHSS 1975), there was a growing lobby for specialist community training for mental health nurses. The Joint Board of Clinical Nursing Studies (JBCNS) established a committee to examine requirements for an approved community psychiatric nurse (CPN) course which did not overlap with the requirements for district nurses or health visitors. It was agreed that a separate course was needed to produce highly trained nurses who could meet the specific needs of mentally ill people. In 1974 the JBCNS published the *Outline Curriculum in Community Psychiatric Nursing for Registered Nurses* (JBCNS 1974). This 36-39 week course was designed to prepare a Registered Mental Nurse (RMN) or a Registered Nurse of the Mentally Subnormal (RNMS) to work in a multi-professional environment and to give both rehabilitative and therapeutic care in the community. A major element of the course was community placement, particularly with the community psychiatric service, which the student would join after qualification (White 1990).

White notes that the CPN course curriculum had been designed to meet the perceived development and increase specialisation of community nursing for both the mentally handicapped and mentally ill (JBCNS 1979). It was divided into three sections with a core element followed by specialisation. For the mentally ill the emphasis was on care of young and elderly people whilst in learning disability it was on acting as an enabler and promoting self help and social skills in the community.

The first CPN course was started by Chiswick College in 1973 (White 1990) and, by the end of the 1970s, CPNs had achieved independent recognition and other colleges and polytechnics were running courses. CPNs worked from general practice clinics or accepted referrals from other agencies, and developed specialist skills to assist and work with care groups and organisations (Simmons & Brooker 1990). From its inception, CPN training has remained outside any national examination system. Little outcome research has been done on its effectiveness and the quality of training remains dependent on the quality of the institutions providing courses (White 1990).

A major theme of the educational developments described above was to highlight the distinctive contribution of psychiatric and learning disability nursing and to distance them from general nursing. However, it was not long before separate moves were to completely undermine this initiative and reunite these branches of nursing under the single banner of Project 2000 (UKCC 1986) - now known as the Diploma in Higher Education (DipHE). We discuss these developments further in Section 3.2.

3.2 THE DIPLOMA IN HIGHER EDUCATION AND ITS PERCEIVED IMPACT ON MENTAL HEALTH AND LEARNING DISABILITY NURSING

The move towards greater academic status for nursing and nurse education in the UK is reflected in a number of developments in the 1970s. Increasing numbers of nursing studies departments were set up in universities and polytechnics to offer bachelor degrees and a nursing qualification (mainly in general nursing) and higher degrees. Publication of the *Journal of Advanced Nursing*, the first issue of which, in 1976, promoted the image of nursing as a profession demanding high academic standards in both practice and research, gained a place as an academic journal rather than a professional magazine (Baly 1980). The developing ideology, which encouraged nurses to perceive themselves as more than an extension of medical practice, began to challenge the traditional medical model and to demand increasing opportunities for academically recognised continuing education and training opportunities in nursing beyond initial registration.

Project 2000 was the most radical of all the educational reforms of the 1980s with its emphasis on college based education, rather than hospital based apprenticeship, leading to the diploma in higher education (Baker 1987). Based upon the foundation of a single initial nurse grade (registered nurse), the new programme requires pre-registration nursing education to be obtained through the higher and further education sectors with their academic entry requirements. The course aimed to reverse the falling numbers of employed nurses. It argued for better interpersonal skills training for all nurses and supported the move from hospital to community care.

We now have two main routes of educational preparation for nurses at pre-registration level: degree programmes and DipHE courses. There remain traditional registered nurse certificate courses in some nursing colleges but these are disappearing as courses are completed and recruitment to the diploma and degree courses expands.

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The concern now is whether these different courses are producing different kinds of practitioner. Bircumshaw (1989) has argued that graduate nurses differ in their practice with regard to assessing and planning and have difficulty in adjusting to the caring environment because of their theoretical background. Winson's (1993) research found a number of curricula differences across degree and diploma courses particularly in terms of the use of research, assessment of coursework (degree courses have twice the amount of coursework as diploma courses), the numbers of lecturers and class sizes (degree departments tending to be much smaller). While *et al* (1994) compared the performance of general students from degree, diploma and RGN nurse education programmes. They found few significant differences between the three programmes except for the following:

- the RGN and degree students were better than Project 2000 diplomates in planning patient care
- the degree students used a more systematic method of seeking information for care planning than the Project 2000 students
- the RGN students made more use of a nursing model in their care planning than the Project 2000 and degree students
- observed performance of the degree students was better with respect to:
  - promotion of health and patient teaching (than RGN students)
  - care management, organisation of work and communication skills (than Project 2000 students)
  - use of the nursing process in planning care (than both the other groups).

These findings should be accepted with some caution, however, because of the then short lifespan and teething problems of Project 2000 courses and their much larger student numbers. Project 2000 students had much less clinical practice time than the others and so it is not surprising that they fared relatively badly. It would be misleading to infer from this study of general students to those in mental health and learning disability.

Project 2000 emphasised the common ground between different areas of nursing, in particular mental health and general care. As a result, all students on the Project 2000 course had to take the CFP spanning the first 18 months. The aim was to raise standards and morale, but the greater emphasis in the CFP on general nursing at the expense of the specialties was much criticised (White *et al* 1993).

The Royal College of Nursing (1993) pointed out that, as far back as 1968, the Joint Sub-Committee of the Standing Mental Health and Standing Nursing Advisory Committee had acknowledged the important relationship between psychiatric nurse training and the quality of mental health nursing (Ministry of Health 1968). That committee had concluded that separate training and qualification (registered mental nurse) was essential.

Some 25 years later this same issue remains prominent in the debate on nursing education. In 1962 psychiatric nurses were required to take the same intermediate examinations as general nurses. Specialisation followed thereafter. It seems to many somewhat ironic that the proposed DipHE format for the 1990s would require mental health and learning disability nurses to do much the same.

Project 2000/DipHE was the result not only of an extensive consultation process but a costing exercise by the auditors, Price Waterhouse. Their favourable financial report did much to convince the government of its benefits (Jones & Jones 1992). By creating specialists trained to at least diploma level, who would be sufficiently flexible and resourceful to cope with most circumstances, the DipHE course would produce skilled professionals ideally suited to meet the challenges of community care at minimum cost. Thus, the community reforms provided an opportunity to maximise the use of a then decreasing supply of resources in what was perceived to be the most efficient and cost effective way and, in many cases, avoiding the need for expensive re-training to fit hospital nurses for work in the community (Jones & Jones 1992).

3.3 THE IMPACT OF THE INTERNAL MARKET: SKILL-MIX AND THE TRAINING OF NON-REGISTERED WORKERS

In political and organisational terms the way in which nursing education has been managed has changed since the NHS reforms of 1974. The new post of director of nurse education was created and made directly accountable to the General Nursing Council. The 1974 reforms also saw amalgamation of smaller schools of nursing into district or area schools offering training on more than one part of the Register and Roll. Post-basic and continuing education and in-service training became the responsibility of these new schools and greater links were forged with service providers.

Neither *Patients First* (DHSS 1979), nor the Griffiths Report, that promoted general management in the NHS akin to the private sector (Griffiths 1983) were intended to disturb nurse education fundamentally. But *Patients First* required directors of nurse education to liaise closely with directors of nursing services in individual hospitals. The variation in nursing policies between hospitals increased and made it difficult for educationists to ensure continuity of placement experience for students. The Griffiths Report urged control of expenditure and value for money which led to close scrutiny of educational packages and demands for educational institutions to demonstrate the effectiveness of their programmes.

Although the potential benefits of a well educated nursing workforce are recognised, concerns have been expressed. Wagstaff (1991) argued that increased academic status will produce managerially oriented nurses who are unwilling or unable to do the practical work. The bulk of practical nursing care would therefore rest with support workers. The opposing view is that the academic development of nursing increases the repertoire of abilities nurses possess and their motivation to remain in direct clinical care work. However, an increase in the proportion of support workers to nurses is seen to be the objective of many service providers in their pursuit of acceptable service quality at the lowest possible cost. This objective persists even though skill-mix research shows a direct relationship between grade of nurse and quality of nursing care (Carr-Hill *et al* 1992). It is to the training and management of these support workers that we now turn.

In learning disability and, to a lesser extent, in mental health the bulk of the workforce is provided by support workers, with varying degrees of in-service training, who provide direct care both in hospital and the community. The need to provide formal qualifications for these workers is now recognised (DHSS 1987) and the momentum to improve their status and their preparedness, through national vocational qualifications (NVQs), is increasing.

The National Council for Vocational Qualifications, an independent government-funded body established in 1986, introduced a framework of competence based qualifications for a range of occupational groups and work contexts (Elliott-Cannon & Harbinson 1995). National standards of performance were defined at four levels for each NVQ and assessed by awarding bodies (CCETSW and City & Guilds jointly, and BTEC). In 1992 people working in health and social services were able to gain NVQs in Care, which were based on standards of care defined at levels 2 and 3 by the Care Sector Consortium. From a generic base, the support worker will be able to specialise in learning disability care on a properly validated course. The National Council for Vocational Qualifications intends to validate courses for professionals and non-professionals. By doing so it aims to improve the quality of training, be employment-led and offer transfer across professional boundaries so endorsing government commitment to a national system of vocational qualifications. The ENB has taken a while to embrace vocational training for support workers in nursing but it has recently taken part in discussion with the Care Sector Consortium:

> ' ... concerning competencies and the interrelationship of professional awards, vocational qualifications, competencies and standards.' (Elliott-Cannon & Harbinson 1995: 8).

Clifton *et al* (1994) have produced a 'template for training in transition' to guide development of competence based training and academic based education programmes within an inter-professional framework. The national qualification framework ranges from the national curriculum of school education and GCSEs to higher degrees. It shows the relationship between different qualification systems and equivalence between different NVQ levels and GCE 'A' levels and university degrees. NVQs provide qualifications that facilitate entry into employment and continuing learning, whereas GNVQs (General National Vocational Qualifications) are more 'academic NVQs'. The NVQ level 3 is regarded as equivalent to the Advanced GNVQ and GCE A level, the NVQ 4 and GNVQ 4 match the first degree and the NVQ 5 the higher degree.

The differences between competence and academic models of training and education are fast disappearing but, for clarity, Clifton *et al* (1994) caricature them thus:

- competence models are work based, the employer takes priority, and assessment is through observation which is outcome-focused, criterion-referenced, repetitive and inclusive
- academic models are college based, the student takes priority, and assessment is through written work which is process-focused, norm-referenced and based on one-off sampling.

The framework recognises the value of service users contributing to staff training and education, the need for staff development to focus on user needs and the importance of negotiation, collaboration and partnership to ensure success in bridging vocational, academic and inter-professional training and education.

The internal market for health care and for education highlights the contrast between the government's aim for service-led training and the education-led ambitions of higher education and the nursing profession. Outlining its intentions in ***Working for Patients***, Working Paper 10 confirms the government's wish to see specialist training being sought by trusts and purchasers of services (Department of Health 1990b). Further, it sees benefits accruing from proper training and recognition of skills in improved staff morale, better recruitment and greater loyalty from staff. Against this we see that from 1981/82 to 1991/92 there has been a drop of over 50% in entrants to mental health nursing and learning disability courses (RCN 1993). Working Paper 10 gave regional health authorities responsibility for calculating future workforce needs and determining corresponding educational requirements locally. This has resulted, in many cases, in a reduction in education purchasing. As a result, in 1992 almost two-thirds of CPNs nationally did not hold the CPN qualification and, although educational institutions reported near full subscription to such courses, one in three places remained vacant.

The Royal College of Nursing (1993) has identified trends which indicate the way forward for mental health nurse training. On the one hand, CATS have given credit for learning achievements such as life experience and knowledge gained from other courses, so fuelling the move towards the generic approach. On the other, the government's recognition that people with serious and enduring mental illness need to be prioritised points to the need for new and specialist training in this area.

The recent statement of strategic intent by the Department of Health challenges all stakeholders - the NHS Executive, the statutory bodies, all health professionals, health care purchasers, health care providers, education commissioners and education providers - to:

> 'talk to one another, to act together to achieve a dynamic yet mature, stable system of education and training which is patient focused, practice led, student centred, equitable, appropriate, effective, responsive, collaborative and accountable.' (Department of Health Nursing, Midwifery and Health Visiting Education Forum 1994: 11)

3.4 SOCIAL WORK AND NURSING

In 1980, the General Nursing Councils and CCETSW were asked by the Secretary of State for Social Services and the Secretaries of State for Scotland and Wales to convene a Joint Working Group to report on the training needs of staff caring for people with mental handicap. The ensuing reports (GNCs/CCETSW 1982, 1983) were heavily criticised in that they were considered not to have gone far enough down the road of shared learning for staff in all settings - local authority, private and voluntary - that offer services to people with a learning disability and their families. A seminar to stimulate discussion on cooperation in training was convened by the Department of Health and Social Security for officers of the new ENB and CCETSW following publication of the two GNCs/CCETSW reports. The mood of the seminar was stormy, as Elliott-Cannon and Harbinson (1995:10) describe:

> 'The atmosphere crackled with apprehension and apathy as some participants were convinced that there was a plot to undermine or replace existing qualifications and that the differences were so great as to make co-operation unworkable.'

In the end, however, each organisation began to appreciate the contribution of the other and they recognised the scope for cooperative progress.

The next step was the award of funds in 1985 by the Department of Health and Social Security to CCETSW to develop a 5-year Learning Difficulties Programme that would emphasise shared training. This was followed, in 1986, by the CCETSW/ENB Working

Group set up to encourage cooperation in education and training in learning disabilities at pre- and post-qualifying levels. The report of the Working Group (ENB/CCETSW, cited in Elliott-Cannon & Harbinson 1995) recommended three models of shared training:

- 'the opportunistic design: sharing of lectures and placements
- the partially integrated design: a three year programme to integrate the CSS/CQSW and RNMH, with some students gaining both qualifications
- the future design: this anticipated the sharing of common elements between Project 2000 and the CQSW' (Elliott-Cannon & Harbinson 1995:11)

During the five years following 1986, the ENB and CCETSW collaborated in joint conferences and research studies to agree procedures for joint validation of training in learning disability nursing and social work. The outcome was two pre-registration courses leading to the award of the Certificate of Social Studies (CSS) and RNMH, one in Kent (South-East (Bromley) CSS and Tunbridge Wells District Health Authority) and the other in Essex (North-East London CSS and Basildon & Thurrock Health Authority), and a post-registration course run by the Bedfordshire School of Nursing and Social Services Department. Other shared post-registration courses were running in Wales too and, by 1991, there were nine validated courses in learning disability at post-registration level altogether (Elliott-Cannon & Harbinson 1995).

Evaluation of these pioneering courses followed (CCETSW/ENB 1989, Walton & Brown 1989, Graham 1992, Brown 1993, Ramasawmy & Harbinson 1993, Evans & McCray 1994). Findings included positive changes in the care of people with a learning disability, the importance of reaching a shared understanding of language, the need for flexible educational frameworks and the need to develop competence based training that incorporates CATS. Although teething problems and conflict between the social work and nursing organisations occur still, there is widespread support for shared training and learning in learning disability (Elliott-Cannon & Harbinson 1995). Conflict between the organisations, also noted by the RCN Society of Mental Handicap Nursing (1989), is detrimental to service provision but, by the late 1980s, barriers were being eroded and equal opportunities offered in employment and training. The introduction of community learning disability teams enhanced this integration and showed that social workers and nurses can work well together to serve the user.

Social workers, the professional group which has perhaps benefited the most from community care reforms, have argued for some time for genericism and, in many ways, their formal training reflects that. The CSS is the service-led qualification and the

Certificate in Qualified Social Work (CQSW) is considered to be the higher qualification leading to an academic award. Both certificates are regarded as generic social work qualifications after which a learning disability specialism can be taken, along with other specialisms. The 3-year RNMH is, by contrast, a specialist programme which could, before the advent of the DipHE, be taken as dedicated specialist courses. In 1989 a new 2-year Diploma in Social Work for social workers and probation officers replaced the old CSS and CQSW certificates (Elliott-Cannon & Harbinson 1995).

The changes in social work and nursing training, from certificate to diploma (the Diploma in Social Work and Diploma in Higher Education) disrupted the links that were being forged over learning disability education between CCETSW and the National Boards for nursing, but both diploma courses are now being reviewed with further changes expected (Elliott-Cannon & Harbinson 1995). Under discussion is the potential for shared learning and joint training. The areas of overlap between social work and nursing education have increased with the move to community care, particularly in terms of values (e.g. user empowerment) and curriculum content (core knowledge and skills include counselling and psychological therapies, for example). Also clinical supervision, which is now attracting such attention in nursing, has been established practice in social work training for decades. Some validated joint courses are already up and running, such as the course at the University of Portsmouth and the one run jointly by South Bank University and the South East Thames Consortium, which award the Diploma in Social Work and the RNMH.

The pace of change in policy, care provision and education has been formidable for nursing and social work since the 1980s. CCETSW sees it as essential to integrate training in learning disabilities and to encourage flexible liaison between health and social services so that users can move smoothly through facilities (Elliott-Cannon & Harbinson 1995).

3.5 CONCLUSION

More professions - nursing, social work, occupational therapy and other therapy professions - are moving towards graduate status. At the same time some, notably social work, occupational therapy and physiotherapy, have promoted development of 'lower level' competence based NVQs. Nursing has been slower to join this initiative; afterall, it has only recently discontinued enrolled nurse training in its move towards a single first level qualification. There is growing pressure to achieve parity between academic and vocational qualifications to promote a culture of life-long learning where people can move in and out of education and can capitalise on credit transfer schemes across academic and vocational routes. An agreed national framework for the CATS scheme is necessary to avoid fragmentation and abuse.

Shared learning has gained approval in post-basic education, when professional identities are well established and the scientific bases for pre-registration education have been absorbed. Learning disability nursing is holding on to its membership in the family of nursing although it acknowledges the value of integration with social work education. Many health and social care professionals now share ideologies and skills in therapeutic treatment and there is growing recognition of the savings to be made in combining courses and resources. Although the *Post-Registration Education and Practice* report (UKCC 1990) has put forward proposals for post-basic education and made assumptions about its likely effect, not yet confirmed by research, there is widespread approval for the scheme.

The support for shared learning and training recognises that service users also should have an influential voice. The idea of a generic therapist is not widely supported in the literature and there is also disagreement about the wisdom of a generic first level nurse.

The community emphasis also raises the relationship of education to practice; specifically the question of whether educational developments have been proactive or reactive to service demands. We conclude that no long-term, continuous strategy of educational reform has been evident and that changes in service and in education have occurred relatively independently of each other. Nevertheless there seems now to be a synergy between proponents of generic pre-registration nurse education and service providers within the health care market who want a flexible nursing workforce. This is not to say, however, that educationists endorse the pressure they feel from service providers for nurse training to be service-led; their view is that it should meet service needs certainly, but remain student centred and education-led.

We pick up some of the issues raised in this chapter in Chapters 6 and 7 in which we build models of nurse education grounded in our empirical data and interrogate them for coherence and feasibility. First, though, we move to Chapter 4 to describe the approach we took and the methods used in this study.

CHAPTER 4
RESEARCH DESIGN AND METHODS

This chapter provides:
- a statement of the project's aims and objectives;
- an overview of the research design;
- a description of the methods used to collect the data; and
- details of the procedure used to analyse the data and to develop models.

4.1 AIMS AND OBJECTIVES

As noted in Chapter 1, the aims of the study were to:

a) identify the changing educational needs of nurses at pre-and post-registration levels* involved in the practice of mental health and learning disability nursing in different settings;

b) make recommendations to the English National Board in relation to the development of educational programmes at pre- and post-registration levels for mental health and learning disability nurses.

Specific objectives were to:

a) identify community care settings characterised by progressive care practices which reflect the substance and spirit of the NHS & Community Care Act (1990);

b) explore service implications of the Act for practice and the relevance to contemporary educational provision as perceived by mental health and learning disability nurses and other stake-holders drawn from purchasing authorities, provider units, service users and educational establishments.

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* Our respondents did not distinguish between the educational needs at pre- and post-registration levels. They were concerned much more with pre-registration education.

4.2 RESEARCH DESIGN AND METHODS

The purpose of the study led us to engage in two kinds of activity: discovery of existing progressive practice in care provision of mental health and learning disability services - a task for systematic inquiry - and development of models of educational provision that might guide policy makers, educationists and practitioners in the future. These two activities of discovery and development followed three phases: preliminary work, fieldwork, and analysis and model development. The research design took an 'embedded multiple-case study' approach as described by Yin (1989). That is to say, the study consisted of two 'cases', one in mental health and one in learning disability service provision. The 'multiple data points' within each case were represented by the respondents in three sites - three in mental health and three in learning disability. The proposition investigated was that the educational needs of mental health and learning disability nurses are influenced by changing practices in service provision towards a more community based service. The purpose was to gain a broad view of the issues under investigation rather than to compare non-representative sites with each other. The sites provided the mechanism for collecting views from a diverse sample of respondents within each case. Thereafter the data were aggregated across sites within mental health and learning disability and across both specialties.

4.2.1 Phase 1: Preliminary work

Four main activities comprised Phase 1:

Educational provision

Information on pre- and post-registration courses for mental health and learning disability nurses was collected from the ENB, from higher and further education databases and from personal inquiry. This information contributed to selection of the sites and in developing the interview schedules.

Key informant discussions

Interviews with 22 key informants helped us identify sites and explore the substantive issues for inclusion in the interview schedules. The key informants for each nursing specialty were selected on the advice of our Steering Group members and through informal contact along the lines of a snowball approach. It was not our intention to select them on a representative basis; rather, to locate people from diverse disciplines and occupations who had strong views on the subject of our inquiry. This strategy ensured that the sites selected and the content of the interview schedules reflected the range of issues important to service provision and education in mental health and learning disability care.

The interviews with key informants took the form of guided conversations and focused on the following issues concerning care provision and education in mental health and learning disability nursing:

- the development of the role of mental health/learning disability nursing in the light of the move from hospital to community based care and the implications of this change for nursing practice and education;

- the impact on mental health/learning disability nursing of the NHS & Community Care Act and its implications for nursing practice and education;

- the link between education and practice and the position of educationists in informing practice as a result of the community reforms;

- details of any education programmes that have made a significant contribution to cementing the link with care provision since the community reforms;

- characteristics of high quality community care provision for people with mental health problems/learning disabilities and the activities that have been introduced;

- the difficulties of developing high quality community care provision and details of any care schemes where these difficulties have been overcome;

- details of people working in high quality care schemes whom we could contact to find out more;

- advice on the most important criteria for selecting notable courses in mental health/learning disability nursing and details of any courses that have met these criteria;

- what the currently 'hot' issues are for mental health/learning disability nursing; and

- details of other people who would be valuable as key informants and in helping us to gain a clear understanding of developments in this area.

The key informants provided a wealth of material about care provision and education of the two groups of nurses. They made a major contribution to site selection and the formulation of interview questions. The organisations from which the key informants were drawn are listed in Appendix 4.1.

Selection of sites

Six sites in England were sought as a feasible number for study within the resources and time at our disposal. The criteria for selection were:

- type of service (three in mental health and three in learning disability)
- stage of development (in transition or fully operational);
- service provision (progressive); and
- educational links (collaborative)

It was not possible to select on the basis of location nor cultural background of service users; neither geographical nor cultural representativeness were sought although sites serving different ethnic populations were included. It was essential for this developmental project that a diversity of care provision, context and educational links be present in a purposively selected sample of sites. Thus, a detailed process of identification, evaluation and consultation took place during the selection procedure so that this diversity was achieved. In taking this approach an element of self selection occurred which should be taken into account when interpreting the findings.

Six sites were selected from an initial shortlist of 17 and approved by the Steering Group; three in mental health care and three in learning disabilities. It was felt by our advisers that the sites fulfilled the selection criteria as far as it was possible to tell before fieldwork began. It was recognised that the extent to which the sites fully met the criteria, particularly progressive service provision and collaborative educational links, could not be confirmed before the fieldwork was under way. Our definition of 'progressiveness' was simply that the site was judged by experts to have made attempts to address the issues under the NHS & Community Care Act. Time did not permit us to evaluate progressiveness before entering the site, nor to move to another site if the one selected turned out not to be as progressive as first thought. This study did not evaluate progressiveness in terms of user outcomes.

The three mental health sites were located in London, the north west and the south of England. The learning disability sites were in London (a different area), the north west of England and the midlands. The two sites in the north west were purposely selected in the same health authority to provide an opportunity to consider different services within a similar context. Details of each site are given in Appendix 4.2.

Development of interview schedules

Guided interviews were the main method. They were the mechanism we used to learn about service provision, educational experience and the impact of the NHS & Community Care Act as experienced by all the important stake-holders. Interview guides were developed and discussed at length for their relevance and feasibility with members of the Steering Group. The guides were tested during preliminary work in the first site. What was required was a schedule that was sufficiently structured to ensure that respondents were asked about the same topics yet was fairly open to allow a certain amount of flexibility in the nature and content of the questions asked. One interview guide was not suitable for all the respondent categories; six were developed (see Appendix 4.3):

1. for service managers and 'workers' (nurses and support workers who were involved in nursing activity)
2. for lecturers and other teachers
3. for users and carers
4. for advocates
5. for doctors, other therapists, executive managers, purchasers
6. for students

The topic guide for service managers and workers was the lengthiest and the most commonly used. It covered the following areas:

The organisational structure of the service

Questions in this section were asked of the service manager only so that the organisation could be understood. Covered were such details as links with purchasers and educational providers, the philosophy and management of the service, changes implemented to meet the requirements of the NHS & Community Care Act, quality assurance and audit procedures and policies on identifying community needs and on advocacy, user rights and involvement.

Locating the respondent in the organisation

Information was sought on the workers' job title and grade, previous experience and qualifications, user groups worked with, educational responsibilities and links with the wider organisation.

The process of user referral and management

The purpose of this section was to understand the process of care delivery within the organisation and the values held by the worker that informed the process.

Principal components of work

Respondents were asked to identify the main components of their work, then to specify the competencies required for successful performance of each component, how these competencies had been acquired and their educational implications. These questions served to locate implications for the education of mental health and learning disability nurses within care provision.

Educational experience and its contribution to role performance

The purpose of this section was to help respondents assess the extent to which their educational experiences, formal and informal, and the competencies acquired contributed to successful work performance.

The nature of the respondent's work in relation to other health care professions

Questions in this section referred to the nature of multi-professional teamworking, boundary demarcation and the feasibility and desirability of multi-professional education.

Aspects of service delivery related to the NHS & Community Care Act

This section addressed management of specific features of the Act within the service and their implications for education.

The interview ended by asking respondents to describe their vision for service development and its educational implications over the next five years.

It is inevitable in an exploratory study of this kind that omissions in the questions asked arise. Issues that were not raised deliberately but were discussed if they arose included welfare rights of users, the needs of people from social minorities, views on user-led services and how to empower users. We also did not include a question to users on their views about future service developments. The other groups were asked this and the user view would have been of value. A few questions put to users referred to their residence, involvement with staff and daytime activity. We asked these in order to get a picture of users, their activities and what they required from staff rather than to describe users and their personal difficulties in any detail.

4.2.2 Phase 2: Fieldwork

The fieldwork in the six sites took place between November 1993 and October 1994.

Access and ethical clearance

During the process of site selection a key liaison person was identified with whom access and interview scheduling was negotiated. This person was a key player in the site and available for speedy contact when the need arose. A letter of request was followed up by a telephone call. The letter outlined the purpose and procedure of the project, why the site had been selected and a request for participation. It asked that, if interest in participation was forthcoming, an access meeting with key personnel be set up and documentation about the organisation of the service be provided. All six sites indicated a willingness to participate although they preferred not to commit themselves finally until the access meeting.

Access meetings were then arranged at each site; the research team was represented by three members except at the first site when four attended. The meeting began with an explanation of the genesis and purpose of the study and what participation would involve. We emphasised that individual participation was voluntary, that all data would be confidential and that sites and individuals would be rendered anonymous in reports and publications. The final item on the agenda was to identify appropriate people to interview - frontline workers (nurses, therapists, care workers), managers, lecturers, other therapists and doctors, users, informal carers and students.

Clearance through the local ethics committee was obtained in four of the sites. In the other two (both learning disability) clearance by the management committee or chief executive was required rather than through an ethics committee. In the London mental health site, a drop-in centre specified that ethics committee clearance was not necessary although approval by their User and Staff Group was. Whichever route was followed, ethical clearance was granted in all the sites.

In each site a list of potential interviewees and their posts, including users and their carers, was drawn up by the liaison person after which the research team selected names from this list. It was important that we retained control over the final selection of people to interview to ensure that all stake-holder groups were included. A programme of interviews was arranged with the liaison person. Each interviewee was sent a letter that described the aims of the project, why the site had been chosen and why s/he had been selected for interview. Assurances of confidentiality and anonymity of participants and sites in all reports were given.

The letter was followed up with a telephone call to provide further information as required and to confirm willingness to participate. The liaison people in all the sites were

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extremely helpful in organising the interviewing schedule so that our time at the site was used as efficiently as possible. The interviews took place mostly in a conveniently located room at the site or at the interviewee's place of work if preferred. We interviewed users and their carers in locations of their choosing; in their own homes or in the more formal setting of a health centre or hospital. Most of the respondents were interviewed separately. The exceptions were group interviews with students and, if users preferred to be interviewed together with a carer or advocate, this was respected.

The programme of interviews

Whenever possible the fieldwork took place during a single period; this was particularly important in the sites furthest away from our base. In several sites, however, we made one or more return visits to complete interviews that could not be scheduled during the first visit.

Most of the interviews lasted between one and two hours. The longer interviews were with service managers who gave us information about the organisation of their service as well as their views on service provision, its educational implications and the NHS & Community Care Act. Occasionally an interview had to be foreshortened because of the interviewee's work pressure but, on the whole, the people we interviewed were most generous with their time. We rarely spent as much as an hour with users; the interview was brought to a close when they had given us all the information they could or when it was clear that they had had enough.

Early on in the fieldwork we tape-recorded the interviews. Later on, as we became more familiar with the subject area, we turned to comprehensive note-taking during the interview. We ensured that our note-taking gave a sufficiently reliable and comprehensive account of the interview by using both recording methods with a sample of interviews and checking the notes against the tape-recorded transcript. Verbatim transcription of the interviews was unnecessary for this study. A clear understanding of the interview content could be gained by listening to the tape and extracting relevant information or, when more experienced, by extracting the information as notes during the interview. Comprehensive accounts were written up as soon as possible after the interview and, when relying on note-taking alone, nearly always on the same day.

The sample

Altogether 147 people were interviewed, 88 in mental health and 59 in learning disability services. The total numbers within each of the groups are shown in Table 4.1.

Table 4.1 ***Number of interviews by category in each site:***

site	1				2	3	4	5	6	total
	mhs	dic	hct	total						
managers	7	1	8	16	4	4	9	8	4	45
workers	5	0	5	10	2	12	7	5	4	40
other professionals	4	1	4	9	5	3	3	2	0	22
lecturers	1	1	2	4	2	2	6	3	0	17
student groups	1	0	1	2	1	1	1	1	1	7*
users & carers	0	3	0	3	3	2	1	1	2	12
advocates	1	0	0	1	1	1	0	1	0	4
total	19	6	20	45	18	25	27	21	11	147

legend
mhs - mental health service
dic - drop-in centre
hct - homeless care team
*13 students altogether

The manager category contains service managers, executive managers and purchasers. Workers consist of nurses and other staff who gave direct care to users. The other professionals include psychiatrists, psychologists, occupational therapists and social workers. Site 1 contained three services - a mental health service, a drop-in centre run by MIND and a primary care team for homeless people. The interviews held in each of these services are given separately in Table 4.1 as well as the total number.

4.2.3 Phase 3: Analysis and model development

The analysis procedure consisted of two stages that took us through a process from descriptive analysis of the data from each site to the developmental work required for model building.

Stage 1

Stage 1 consisted of the following steps:

1 A comprehensive account of each interview, structured under the headings of the interview schedule, was produced as soon as possible after the interview.

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2 Each question was analysed across all six interview schedules, if relevant, for the mental health and learning disability respondents separately and for the total sample.

3 The responses to each question were classified into 'views' that summarised a topic area. For example, two of the views that emerged in response to a question on the respondents' experience of care/case management were:

Social workers not always the best care/case managers
Vesting responsibility for care/case management only with social services departments and social workers is questioned. It may not be conducive to good team working and some professionals maintain that nurses can be as good, or better, care managers because they can give hands-on care at the same time so serving the user more efficiently.

and

Discharge planning requires coordinated health/social services planning
Care/case management requires the team to consider discharge and future care (i.e. the Care Programme Approach). It is unhelpful that care/case management is owned by social services and the CPA by health services. Both should be integrated with one combined form for completion (at present there are separate forms). Nurses need to understand 'supervised discharge planning' for this integration to be successful.

4 For each question a count was made of the number of respondents who contributed to each view, broken down by site and interview schedule, for mental health and learning disability separately and for the total sample.

5 The most prominent views for each question were described under three headings:

- Service - its nature, structure and process
- Practitioners - their personal characteristics
- Education - needed by practitioners.

The views considered prominent were selected on the basis of their frequency counts (step 4). Views that were mentioned by at least 7% of the mental health respondents, the learning disability respondents or the total sample are described under the three headings (percentages of the smaller subgroups - the sites and type of respondent - are not reported because of their small numbers). This arbitrary cut-off point of 7% ensured that the most frequently endorsed views predominated but it also allowed us to give prominence to some of the views considered important by only a few respondents. Where respondent numbers are small, their percentages should be treated with due caution, however.

Most of the prominent views could be described under each of the headings, although not quite all. In that case the cell of the analysis table was left unfilled. For each question, one analysis table presents the views endorsed by both mental health and learning disability respondents, a second table includes views endorsed mostly by mental health respondents, and a third includes views endorsed mostly by learning disability respondents. By way of illustration, Table 4.2 shows an example of an analysis table from one of the questions, endorsed by mental health and learning disability respondents.

Table 4.2 Domiciliary, day care and respite services: views shared between mental health and learning disability

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V2 MH 16 (18) LD 14 (24)	Proactive resourcefulness to make best use of the service infrastructure for the benefit of users	Proactive initiators rather than reactive copers	Shared learning so that all professionals have knowledge of the services available and how to network effectively
V8 MH 10 (11) LD 9 (18)	Flexible user-led services that acknowledge the risk-benefit balance necessary for ordinary living	Become responsive to a user-led approach and accept that a level of risk is necessary for wellbeing	Shared learning increases knowledge and promotes flexibility and openminded attitudes to a user-led service
V6 MH 6 (7) LD 9 (15)	Day care should be more flexible, imaginative, integrated into the community and involve users in care planning	Become lateral thinkers so seeing possibilities beyond the stereotyped service	Shared learning would expose nursing students to the techniques and inventiveness that other professionals use to achieve the best services for their users.

(MH = mental health, LD = learning disability)

Each of these prominent views was described in detail together with the frequency of response by site and respondent group. The three views in Table 4.2 - to do with proactive nurses, flexible nursing practice and flexible and imaginative day care - were described thus:

View 2
A strongly expressed view was that nurses need to take a proactive role. They need to learn to campaign for increases in service provision and to be active in facilitating change. They need to be resourceful in filling gaps in care, able to find out the range of services available locally so that they can refer users, and know how to network effectively. Service infrastructure is as important as case management. Nursing has a lot to learn from social work and shared learning by students would help nurses to acquire networking skills. Learning disability nurses need training in assessing health care needs and how to influence GPs to accept interventions to meet social care needs.

This view was most often endorsed by MH respondents from Site 3 (8), Site 1 (6) and Site 2 (2). It was identified notably by workers (6) and managers/other professionals (8). Two responses were received from a quarter of the lecturers.

For LD respondents this view was primarily an issue for Site 4 respondents (11). Two responses came from Site 5 and 1 from Site 6. This view was most often endorsed by managers/other professionals (7) and workers (5). The remaining 2 responses were from lecturers.

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View 8
Nurses need to become more flexible so that they can find the best package of services for users with different problems and preferences. Both clinical and social needs of users should be considered equally. Nurses need to learn to work in user-led situations which means that they must be prepared to accept a certain level of risk if that is what it takes to achieve a benefit. Needs-led assessment leads to tailor-made packages of care which are a great improvement on traditional care. Nurses must accept user involvement in the planning of services, and must be aware of users' different beliefs about, and attitudes towards, the services.

This view was of some interest to MH respondents with 3 responses from Site 2, 5 responses from Site 1 and 2 from Site 3. There were 4 responses each from workers and managers/other professionals. The remaining 2 responses came from a lecturer and a user/carer.

This view was relatively more common amongst LD respondents where 3 of those from Site 6 and 5 from Site 4 identified it. Four managers/other professionals identified it, with 2 responses each from workers and lecturers and 1 user/carer.

View 6
Day care needs to be flexible and more imaginative. Nurses should be encouraged to think laterally and not to see services in a stereotypical way. There should be a range of options to meet different needs. Day care should be integrated into the community and be adapted to the needs of informal carers. Users and their families should be involved in the planning stage. Homeless people using day care should be encouraged to use it constructively, not just as a place to drop in for a cup of tea. The safety aspect of day care is often ignored and concern was expressed about mixing men with women.

Users need a 24-hour service over the whole week rather than one that is closed after 5pm and at weekends. Day centres for people with a learning disability tend to be run as adult crèches, which is demeaning and stigmatising for users. Day care that integrates its users into the community so that they feel like ordinary people participating in ordinary work and leisure activities, meets users needs to the greatest extent.

This view was supported by some MH respondents: 4 workers each from Site 1 and 2. Four managers/other professionals identified it with single responses coming from a worker and a user/carer.

This view was relatively more common amongst LD respondents: 6 from Site 5, and 3 from Site 4. Four workers and 3 managers/other professionals identified it. There were single responses from a lecturer and a user/carer.

This stage of the analysis provided the bulk of the raw data, details of which are provided in Appendix 5 and Appendix 6.

Stage 2

Stage 2 describes the process we followed to identify themes and develop models inductively from the data. It contained several steps which began with data aggregation followed by interrogation from the literature and expert professional judgement so moving towards a form of normative modelling:

1 Major issues across all the data were extracted from the prominent views identified in Stage 1. This strategy ensured that we focused on the issues considered most important by the respondents with reference to the educational implications of the move to a community based service.

2 Similar issues were grouped into broad categories; for example, Category 1 - 'responding to the demands of multidisciplinary teamwork', Category 2 - 'the foundation disciplines'. Some of the issues within a category contained just one view whereas several views contributed to other issues. The view code and whether it had been identified by both mental health and learning disability respondents or one of the groups alone was recorded against each issue so that the source of the contribution could be identified and verified. For example, 6.2.2V1J refers to the interview question within Appendix 6 (6.2.2), the view number (V1) and that it was raised by mental health and learning disability respondents (J). The suffix for mental health only views is MH and, for learning disability only views, LD. The categories are listed in Appendix 7.1. As an example of the procedure we used to collect the respondents' views into categories, we include some of the issues that emerged within Category 1:

Category 1 Responding to the demands of multidisciplinary teamwork
6.2.2 V1J; 6.2.3V1MH; 6.2.1V1J; 5.7V2J Provision of a holistic, user-led service requires nurses to lead in health and social assessment and collaboration with others (e.g. to identify unmet needs in the community). Requires pre-registration training in social and health related assessment skills, the scope of service provision and challenges to multidisciplinary working and how these can be met.

6.2.2V3MH; 6.2.8V1J, 6.2.15V16LD, W5.2-5.6V7J, W5.2-5.6V4MH, W5.2-5.6V11J Professional boundaries should be maintained within multidisciplinary teams otherwise inefficiency will result. Nurses need to have a clear role identity and avoid becoming 'jacks of all trades'. They must have a strong professional management structure and a clear identity which will persuade other team members and purchaser and provider organisations of the value of their contribution, although some common goals are essential for joint working. Requires education to provide a clear specification of the nature of mental health nursing and negotiation skills. (Contrasts with 6.2.2.V1J).

6.2.2V3MH, W5.2-5.6V2J Organisation of effective interdisciplinary working requires user input. Family and carers involved within multidisciplinary team to ensure effective rehabilitation. Requires education to understand the burden of care and the contribution and commitment of the family of patients with long term illness.

6.2.8V4J Separate nursing identity is likely to be eroded by increased emphasis on multidisciplinary training and courses leading to dual nursing and social work qualifications. To avoid this requires shared learning between disciplines rather than joint training.

3 The categories were grouped into themes, such as 'working with others', 'learning formats' (see Appendix 7.1). For example, the theme 'working with others' contains

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two categories: 'responding to the demands of multidisciplinary teamwork' and 'networking'. Developing the categories and themes from the respondents' views was undertaken by one researcher. A second researcher scrutinised the classification that emerged and challenged any doubtful decisions. Discussion of the dubious decisions led to resolution in every case. This procedure of auditing carried out by a second judge is acceptable in achieving consistency (reliability) in the analysis process (Guba & Lincoln 1985).

4 The commentaries to each category were interrogated for their educational implications and expanded by drawing on:

- contrasting views and their rationale
- implications for nurse education
- the literature
- key informant interviews.

The key informants included those who had contributed early on in the study and others whom we interviewed later. As our contacts with the sites progressed during the fieldwork, we inevitably came across influential and knowledgeable people who had strong views and wide experience of mental health and learning disability services and education. We recruited these people as key informants so that we could capitalise on their knowledge when interpreting the findings. Our purpose in drawing from the key informant interviews for this stage of the analysis was to ensure that we were sufficiently informed of the important issues to be able to interrogate the data from the sites. The key informant interviews were not subjected to more substantial analysis. Theirs was an advisory role; first to help with site selection and interview content, as described earlier, and later to inform us of issues important to the interrogation of data. Altogether, we interviewed 45 key informants (the original 22 and 13 more) and we selected the final group using the approach described in Phase 1. The organisations from which the additional informants were drawn are listed in Appendix 4.1.

5 The final step was to integrate the elements from the analysis to build models of mental health and learning disability nurse education. We anticipated that the models would describe ideal types rather than reflect what exists. That is to say, they would be presented as caricatures of extreme views, so that the differences between the models are clearly distinguishable.

This second stage of the analysis provided information that forms the basis of Chapters 6 and 7.

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The process of analysis that we took for this project constituted a somewhat unusual approach to research and development. The analysis depends on rigorous empirical discovery and critical development, an approach that is not unusual in policy-related research and development. It has been used in research into total quality management (Joss & Kogan 1995), medical audit (Packwood *et al* 1994) and clinical audit (Kogan & Redfern *et al* 1995). This process enabled us to summarise the key educational issues concerning mental health and learning disability stake-holders. Also to put forward normative models of educational provision derived from an interrogative process that is sufficiently credible to guide educationists.

CHAPTER 5

FINDINGS: THE SCOPE OF SKILLED PRACTICE IN MENTAL HEALTH AND LEARNING DISABILITY NURSING

In this chapter we present the findings from the interviews held in the three mental health and three learning disability sites with particular emphasis on requirements for skilled practice. The interview approach taken and the analysis procedure are described in Chapter 4. This chapter draws from the respondents' views that are detailed in Appendices 5, 5a and 6. Appendix 6 covers the questions that refer specifically to the NHS & Community Care Act, Appendix 5a refers to the principal components of the respondents' work, and Appendix 5 covers the remaining questions asked. The findings in this chapter are reported in two sections. Section 5.1 includes the questions that relate to the Act. Section 5.2 refers to the questions that probed other areas of service provision. Included are respondents' perceptions of models of care provision and the future of services in mental health and learning disability nursing since the Act and the community care reforms. Also multi-professional working and the role of mental health and learning disability nurses, and issues relating to advocacy. Students were asked about their experiences of their courses.

Section 2 of the interview guide - on the work components - was not analysed at the same time as the other questions (the departure of the full-time research associate during the analysis period meant that Section 2 had to be analysed at a later date). Although Section 2 asked specifically about the skills required for successful performance on the job, respondents also referred to work-related skills when answering other questions. We have not, therefore, included a separate section in this chapter on work-related skills. Instead, requirements for skilled practice are listed under each question as they apply to the issue under discussion.

The presentation of the findings in Sections 5.1 and 5.2 follow a similar structure. For each question the views common to both mental health and learning disability respondents appear first together with the requirements for skilled practice identified by the respondents. Then the views that were more often endorsed by the mental health respondents are described followed by those of the learning disability respondents. For each group the requirements for skilled practice are also included.

5.1 IMPLICATIONS OF THE NHS & COMMUNITY CARE ACT FOR MENTAL HEALTH AND LEARNING DISABILITY NURSING PRACTICE

5.1.1 Identification of unmet need in the community

Mental health and learning disability

Many views expressed were common to both mental health and learning disability respondents and focused on the implications of needs based assessment. Respondents emphasised that the departure from problem oriented assessment to an approach which emphasises users' strengths and abilities requires development of appropriate assessment tools. They also recognised that needs based assessment requires an understanding of specific social issues that have health implications (e.g. resettlement, cultural differences, housing) which must be taken into account during assessment. Addressing unmet need also necessitates collaborative assessment with other workers using established protocols for multi-professional assessment.

Requirements for skilled practice: needs based assessment using standardised measures; multidisciplinary assessment; multi-professional collaborative planning

Mental health

Mental health respondents identified four more views concerning unmet need which are important to clinical practice. Three out of four of these concern the implications of meeting unmet needs of people from ethnic minorities. Respondents indicated that they worked closely with non-statutory bodies and community workers (e.g. Bengali and Somali representatives). Mental health services in sites with a high ethnic minority population specifically targeted certain ethnic groups (e.g. Bangladeshi women) where it was known that there may be a high level of unmet need. Respondents in all the sites expressed the need to develop ethno-sensitive mental health services and to undertake appropriate training. They reported that resources available were insufficient to meet all unidentified need and there is a danger that carers' expectations would be raised when needs cannot be met.

Requirements for skilled practice: identification of unmet need in ethnic groups; targeting of services for ethnic groups; racism awareness of staff; ethno-sensitive services and care.

Learning Disability

Views concerning unmet need highlighted the limitations of services being run between 9am and 5pm on only five days a week, which fail to provide activities and services in evenings and weekends when unmet need might be at its highest. Other areas of unmet need concerned the lack of adequate respite care, services for people from ethnic minorities, community day centre facilities, drop-in centres and public transport to enable users and carers to get to existing services. Another concern was the failure of services to offer benefits advice or to provide regular and long-term support for users. The lack of formal local strategies to identify unmet need in the community was a frequently expressed view.

Requirements for skilled practice: long-term care skills; meeting leisure and social needs; and ethno-sensitive care of families.

5.1.2 Priority client groups

Meeting the needs of priority client groups, such as people with serious or enduring mental illness or those exhibiting challenging behaviour was highlighted by this question.

Mental health and learning disability

Respondents were concerned about community nurses developing holistic forms of care, which are user-led and incorporate health and social care. Respondents emphasised the need to provide support, rather than supervision and control, for clients with long-term mental illness or those exhibiting challenging behaviour. Holistic models of care which recognise the problems associated with diagnostic labelling and the need for evidence-based practice were identified as important cornerstones for good practice. Respondents also emphasised the need for case managers to assess the overall needs of clients, and their responsibility to act as advocates in challenging traditional forms of treatment which are not in the client's interest.

Requirements for skilled practice: social care assessment working with families; counselling and stress management skills, leading in (proactive) multi-professional assessment; facilitating user participation in assessing needs; commissioning care.

Mental health

The views expressed concerning the needs of people with serious and enduring mental illness included: providing effective services for users and their families; working with the voluntary and private sectors; and providing specialist teams to work with priority

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groups. Respondents recognised that working with people with serious and enduring mental illness requires a good collaborative working relationship with other professionals and with statutory bodies and voluntary agencies. This kind of working requires good cross-agency communication and referral protocols. But most respondents wanted their professional boundaries protected and a multi-professional rather than an inter-professional model for working with users with complex needs.

Respondents put a lot of emphasis on proactive crisis intervention work, user participation and effective psychosocial interventions in developing good practice. Working with families was also seen as central to effective rehabilitation and to prevent relapse and re-admission. Respondents indicated that users with long-term problems and challenging behaviour need intensive community support from specialist teams with high levels of expertise. Out-reach services for appropriate users with serious and enduring mental health problems were seen as necessary to provide intensive and out-of-hours services for by both users and carers.

Requirements for skilled practice: forming collaborative and empowering relationships with users; psychoeducational models of family work; psychosocial interventions for control of positive symptoms (delusions and hallucinations); risk-assessment; risk management; de-escalation techniques for violence and aggression; break-away techniques; crisis intervention skills; working with users who do not comply with medication; multi-agency working (across statutory and voluntary services); and assessment of prodromal symptoms indicating relapse.

Learning disability

Emphasised was the need to develop practice in managing people with challenging behaviour using techniques that avoid an overtly behaviourist approach but focus on understanding the causes of this behaviour. Also emphasised was the need to develop services for challenging behaviour which address user empowerment. Respondents recognised the unique problems of people with both a learning and physical disability, who require a uniquely specialist service. Dual training with social work in managing people with a dual diagnosis was proposed.

Requirements for skilled practice: forming collaborative and empowering relationships with people who exhibit challenging behaviour; assessing challenging behaviour; responding to challenging behaviour by drawing upon evidence based methods (such as behaviour modification, gentle teaching); personal stress management skills; and generic medical nursing skills for clients with multiple needs (pressure sore prevention, limb positioning, managing feeding difficulties, incontinence).

5.1.3 Care/case management

This question covered views about care/case management and responsibility for budgetary control.

Mental health and learning disability

Views focused on the implications of the case management arrangements set in place by the NHS & Community Care Act and the community care reforms. Respondents identified the need to develop sophisticated key worker or case management skills, with nurses able to take responsibility for assessment, prioritising needs and the measurement of outcomes for client-centred individualised programmes. There was also an acknowledged need for practitioners to be well informed about current policy and legal requirements, in order to ensure users' needs are met within changing service provision.

Respondents acknowledged the problems associated with budgetary responsibility and control resting with one organisation, the social services departments. The view was that these arrangements had led to another layer of bureaucracy. Learning disability respondents, in particular, expressed the view that a budgeting strategy which operates through service brokerage is the most appropriate case management model. Others, though, feared that case management with budgetary responsibility might lead to an erosion of hands-on clinical skills.

Requirements for skilled practice: needs based assessment using standardised instruments; incorporating user choice in planning and prioritising care; embracing health and social care (e.g. housing needs); formulating problem statements; monitor, review and evaluate the care process; time management skills; resource management skills; budgeting skills; negotiation and contracting skills; understanding policy issues; and local health and social service guidelines.

Mental health

One view indicated that an inter-professional case management model, with nurses and social workers operating interchangeably, had arisen out of the community care reforms. Another suggested that case management models which emphasise the need to develop or broker specialist clinical skills were essential in delivering high quality care to people with serious and enduring mental illness

Requirements for skilled practice: ability to provide effective research-based interventions; crisis intervention; autonomous practice; out-of-hours working; assessing user's dependency; prioritising caseloads; and collaborative discharge planning with social services.

Learning disability

Respondents argued for a user-led service with closer liaison between nurses and social workers, and the need for individual service contracts or a service brokerage model of case management. Another view emphasised that nurses as case managers/key workers should gain a broad understanding of statutory powers in order to lobby effectively on behalf of their clients.

Requirements for skilled practice: skills of service brokerage; clinical case management skills; resource management; case management in the context of legislation and statutory responsibilities.

5.1.4 Process and methods of user assessment

Respondents were asked to describe the process of assessment within their service and assessment tools being used.

Mental health and learning disability

Views shared by mental health and learning disability respondents concerned the use of appropriate assessment tools, user-led assessment and the need for hospital-community liaison. There was a call for nurses to employ a range of standardised tools for the assessment of symptoms. Learning disability respondents were particularly keen on global/holistic forms of assessment.

User-led assessment and self-assessment which emphasise user rights and the identification of need rather than symptomatology, were seen as central to good practice. Good interviewing and interpersonal skills are crucial to assessment and user participation. There was also a heavy emphasis placed on the need for shared discharge planning between hospital, community and social services which would allow continuity in care and rehabilitation. Respondents also identified the need to appreciate the balance between unmet needs and resources, and suggested that nurses should maintain a strong health assessment focus in their work.

One view argued that nurses should act as advocates in identifying user need and putting forward a well argued case for services. Alternatively it was suggested that nurses should at least determine when advocacy is required for a user.

Requirements for skilled practice: interviewing skills; use of appropriate standardised tools for mental health and learning disability which incorporate user-led and self-assessment elements; working with advocacy services; collaborative discharge planning.

Mental health

The views expressed by mental health respondents emphasise the need to develop sophisticated assessment skills for level 1 and 2 assessment. The use of a variety of standardised assessment tools within a holistic framework was seen as central to good assessment. However, respondents also emphasised the need for nurses to develop their ability to use professional judgement and to draw upon their experience and expertise in the assessment process. Risk assessment focusing on aggression and self-harm was identified as crucial to the requirements of supervision registers, and the safety of carers, workers and the general public.

Requirements for skilled practice: professional judgement; using standardised assessment tools; risk assessment of violence, aggression and self-harm.

Learning disability

Two views emphasised the need to establish a therapeutic rapport with users, and to develop more complex assessment protocols focusing on social, psychological and physical needs.

Requirements for skilled practice: use of assessment instruments covering holistic and specific needs.

5.1.5 Community discharge plans

The Care Programme Approach (CPA) specifies the need for community discharge plans.

Mental health and learning disability

Two major views emerged concerning the CPA which emphasise the need for nurses to develop specific skills. Respondents called for nurses to take an active and holistic approach to discharge rather than simply referring the user to outside services. This approach to discharge planning also highlighted the need for regular visits after discharge and provision of crisis services. Respondents saw joint training and assessment as essential for good discharge planning.

Requirements for skilled practice: involving users; assessment, goal-setting, monitoring and evaluation skills; networking skills; collaborative discharge planning; record-keeping skills.

Mental health

There was a strong call for better links between hospital and the community and the development of multi-professional working practices in discharge planning. There was also an emphasis on the need to work flexibly with statutory services and local resources, which requires good networking and communication procedures. Respondents also spoke of the need to develop skills and strategies to cope with non-compliance in users, which was seen as a crucial issue for many nurses when discussing discharge planning. The importance of user participation in discharge planning was seen as essential along with recognition and support for their rights.

The key role of nurse in discharge planning, respondents suggested, requires development of assertion and advocacy skills to ensure adequate and appropriate services. Respondents also recognised the need to be informed of the legislative requirements of the NHS & Community Care Act.

Requirements for skilled practice: working with non-compliant users; promoting user participation; advocacy skills; knowledge of the legislative framework of care; use of health and social needs assessment protocols for discharge planning; understanding the role of other workers involved in discharge planning.

Learning disability

All views are included in the section above along with mental health respondents.

5.1.6 Implications for people from different cultural backgrounds

Mental health and learning disability

Respondents called for a greater understanding of cultural and ethnic differences and for nurses to treat people like individuals, rather than labelling them and making assumptions about their needs. Respondents also acknowledged the need to understand the negative impact of ethnicity on mental health provision. They examined the problems of language and culture, arguing that the use of independent translators is insufficient and that there was a need to recruit nurses from a variety of ethnic backgrounds. The need to be aware of anti-discriminatory legislation was also acknowledged.

Requirements for skilled practice: racism awareness; knowledge of anti-discriminatory legislation; culturally sensitive services; identification of unmet need in users from ethnic minority groups.

Mental health

Respondents called for culturally sensitive services which are both appropriate and accessible to people from ethnic minorities. They also noted that many voluntary agencies are run by Christian organisations which may not be attractive to people who follow other religions. The lack of bilingual workers in many services was a major concern.

Requirements for skilled practice: working with specialist workers and interpreters; culturally sensitive assessment and service provision.

Learning disability

All views are included in the section above along with mental health respondents.

6.1.7 Domiciliary, day care and respite services

Respondents were asked about their experiences of domiciliary, day care and respite services.

Mental health and learning disability

A strongly expressed view was that nurses should take a proactive role in the provision of domiciliary, day care and respite services. They should be active in campaigning for services, in filling the gaps in care provision and be resourceful in their knowledge and use of local resources. There was also a requirement for practitioners to know how to refer and network effectively. Respondents acknowledged the need to develop flexible user-led services, with health and social needs having equal priority. They appreciated that some risk is unavoidable in community living and is necessary for the wellbeing of many users. Needs-led assessment and user participation were again seen as central to the development of good services for people with learning disabilities and mental health problems.

Requirements for skilled practice: user participation in assessing health and social need; risk-assessment; networking with statutory and voluntary agencies.

Mental health

Respondents voiced concern at the numbers of health workers and support workers involved in assessing and delivering services to users. Concern was also expressed about the negative attitude of some domiciliary workers towards users. Now that the nurse is becoming more of a supervisor than a direct carer, supervision of support workers is an important component of good quality care.

Another issue raised by mental health respondents, including users, is the need for an objective and appropriate assessment of the state of a user's home. Too often, we were told, practitioners base their assessments of a user's living conditions on personal value judgements rather than assessment of a health risk.

Requirements for skilled practice: appropriate use of support staff; management and supervision of support staff; valuing standards and expectations of clients.

Learning disability

Learning disability respondents, particularly, stipulated that day care services should be more flexible and imaginative, well integrated into the community and adapted to the needs of informal carers; involving them in identifying suitable services for users, is ideal. There were concerns about the suitability and quality of some day care services. Users often need a 24-hour service over the whole week, which is rarely provided. Day care facilities were criticised for using inadequate, custodial and stigmatising practices, particularly for users with a learning disability. Provision of leisure and social activities, where users feel like ordinary people, are lacking.

Respondents identified nurses as playing a central role in assessing needs and coordinating services for users, the family and informal carers. Nurses require good communication skills and the ability to appreciate the needs of families from diverse cultural backgrounds.

Requirements for skilled practice: multi-professional assessment; multi-professional coordination of services; standards setting; and supervision of support staff.

5.1.8 Collaboration between professionals

Experience of collaboration between professionals within and between health and social services is an important issue in the NHS & Community Care Act.

Mental health and learning disability

Three strong views emerged concerning the role of the nurse in multi-professional teams and the implications for education and training. First was the need for nurses to be clear about their role and responsibilities, which was seen as crucial to maintaining good relationships and respect across professional boundaries. Some flexibility in roles was advocated in acute and community settings to ensure joint planning and common goals. Overall, though, there was a call for nurses to maintain their identity within community services but work jointly with other agencies in an atmosphere of respect and shared purpose. There was considerable concern that professional boundaries might be eroded with increased multi-professional training leading to dual qualifications.

The second view contradicts the first in that it saw collaborative workshops and shared training as beneficial. Proponents of this view felt that joint training and dual qualifications would improve nurses' confidence and work practices given that mental health arises from both social and health concerns. The third view is aligned to the second in that it advocates a single management structure covering all disciplines to promote multi-professional working.

Requirements for skilled practice: networking; knowledge of protocols and referral mechanisms; multi-professional assessment and planning.

Mental health

All views are included in the section above along with learning disability respondents.

Learning disability

All views are included in the section above along with mental health respondents.

5.1.9 Management of support workers

Management of support workers has become increasingly important for nurses in all fields. Respondents were asked how this issue had been addressed following the NHS & Community Care Act. Many of the views expressed were shared by both learning disability and mental health nurses

Mental health and learning disability

Respondents argued that the development of managerial and supervision skills were essential for managing support workers. They saw supervision as fulfilling a supportive and developmental role, and as providing a mechanism for monitoring role performance.

This view suggests that supervision should be supplemented by peer support, and that volunteers, as well as support workers, should be carefully supervised. Nurses can encourage support workers to be autonomous and develop their skills within clearly defined parameters. Respondents felt that induction and continuing training is essential to develop support workers, together with NVQ training and other kinds of external training.

A second view suggested that nurses should recognise the skills many support workers have in meeting user's practical needs. Respondents valued the life experience of many support workers and the style of care they provided for users, which they saw as supplementary to the skills of professional workers. Many support workers develop a close relationship with users and can provide valuable information and feedback on the user's health and wellbeing.

A third view advocated greater team working between professional workers and support workers in which the contribution of the support worker in the multi-professional team is fully recognised. Joint assessment and total team case reviews were seen as the way forward to motivate staff and provide good quality services.

Requirements for skilled practice: supervision skills; management skills; knowledge of relevant legislation; team-building and collaborative working; a clear understanding of support workers' responsibilities and boundaries of work; support of colleagues taking NVQs.

Mental health

Two main views emerged on the management of support workers. First that there was a need for greater role clarity between nurses and support workers. This view argued that support workers should not be key workers and their caseload should be closely monitored by nurses who should encourage support workers to take responsibility but only within clearly defined boundaries.

Second that nurses should be involved in NVQ training at all levels and facilitate the development of these skills. Greater understanding of the competencies, skills and knowledge base would enable nurses to judge the level of autonomy and support required for individual support workers.

Requirements for skilled practice: monitoring support workers' caseloads, supervising their work.

Learning disability

The view that support workers with NVQ training would ultimately replace nurses in the provision of residential care was fairly widespread. Respondents argued that the allocation of individual users to support workers should be carefully coordinated to ensure that users' needs are met.

Requirements for skilled practice: supervising and monitoring support workers.

5.1.10 Support for carers and consultation with users and carers

Mental health and learning disability

Two major issues raised were the need to provide more support for families or carers and to enable users to participate in their care. Respondents argued that not enough attention is paid to the burden for informal carers of constant caring. Families/individuals who care for someone with a learning disability or a mental health problem need more information about the causes of problems and their management. Family psychoeducational work was advocated alongside a better understanding of service availability.

Respondents supported the view that users who participate in the planning and management of their care have the right to make mistakes and welcome nurses who 'care with' rather than 'care for'. User participation also means discussion of diagnosis, drugs and other aspects of treatment. It is recognised that nurses can no longer expect to get away with planning services and therapies without consulting users. Setting up and running community user groups and working closely with advocacy services was identified as an effective way of working with users and family carers. Respondents recognise the importance of responding to criticism from users and carers, even though key workers cannot always keep to this ideal.

Requirements for skilled practice: user/carer participation in care; family work skills; giving information to users and carers; seeking informed consent.

Mental health

All views are included in the section above along with learning disability respondents.

Learning disability

All views are included in the section above along with mental health respondents.

5.1.11 Good access to services (advocacy, brokerage, user's rights and user involvement)

This question asked respondents to consider whether services in advocacy, brokerage and systems for consultation with users had been set in place since the implementation of the NHS & Community Care Act.

Mental health and learning disability

Respondents acknowledged the need to understand the role of independent advocacy for users. They recognised the conflict that can arise for nurses when their advocacy role challenges management decisions concerning service provision.

Views on user involvement emphasised how important it is to meet users at the point of entry into the services, in an accessible, welcoming and non-judgmental atmosphere. Also, how best to involve users in service evaluation. Nurses should have a thorough understanding of civil rights, welfare rights and local health and social service provision. They also need to understand their rights and responsibilities under statute and how local complaints procedures work.

Requirements for skilled practice: working with advocacy services; collaborating with users with a non-judgmental approach; knowledge of welfare rights and statutory responsibilities; knowledge of complaints procedures.

Mental health

Recognising the vulnerability of some users and consistently upholding users' rights are important concerns. Respondents pointed to the value of ex-users' views in providing help in planning service provision.

Requirements for skilled practice: as for mental health and learning disability combined.

Learning disability

Respondents called for nurses to adopt liaison, negotiation and communication skills when working with other professionals. Nurses must network and negotiate with others on behalf of users.

Requirements for skilled practice: knowledge of welfare rights and statutory responsibilities; sophisticated negotiation and communication skills; knowledge of range of services available.

5.1.12 Provision of information for users and carers

Respondents were asked if local services had responded to the requirements of the NHS & Community Care Act concerning the provision of information for users and carers.

Mental health and learning disability

Respondents felt that overall information giving was good, but that the delivery and form of communication could be improved; the process of information giving is as important as the information itself. Ethnic barriers have to be dismantled and user's views incorporated on the nature and format of information to make it accessible .

Requirements for skilled practice: good communication skills; recognition of and sensitivity towards cultural and ethnic issues in information giving.

Mental health

Respondents felt that local information services were poor and that users/carers were often not given information about their illness/condition or service availability. They said that information giving must extend to drugs and treatment. There is also a need for an adequate and well understood complaints procedure, with efforts made to ensure that patients are aware of their rights. Confidentiality was seen as crucial to any information service particularly if user-held records are kept.

Requirements for skilled practice: commitment to user empowerment (through provision of information concerning drugs, treatment, services available and patients rights); ensuring confidentiality

Learning disability

An additional view was the need for expertise in information technology systems and desk-top publishing, so that appropriate information can be provided in formats accessible to users and carers.

Requirements for skilled practice: information technology and publishing skills.

5.1.13 Multidisciplinary training

Respondents were asked for their views on multi-professional training and the changes associated with the NHS & Community Care Act.

Mental health and learning disability

There were strong views on multi-professional training. One regarded it as beneficial to users and carers. It improves joint working practices and promotes team building and consistency in policy implementation. Proponents of this view urged nurses to increase their understanding of the roles of other team members. A note of caution was added, however, in that multi-professional training should not dilute the individuality of the nurse's role nor lead to the evolution of a generic community mental health worker. Another view suggested that multi-professional training should be integral to nurse training and that any exclusivity of roles should be discarded in favour of an interdisciplinary model.

Other views called for joint training on specific issues such as the NHS & Community Care Act, and that training with other professionals would require nurses to examine their values and professional practice.

Requirements for good practice: multidisciplinary working skills (such as joint assessment and planning, regular and formalised communication to enable consistency in case management).

Mental health

There was also a strong view among mental health respondents against multi-professional training because they feared that it would erode the nurse's role. They did, though, endorse multidisciplinary working.

Requirements for skilled practice: as for mental health and learning disability nursing.

Learning disability

All views are included in the section above along with mental health respondents.

5.1.14 Involvement of the private and voluntary sector

This question asked respondents whether local voluntary and private sector care had increased since the implementation of the Act.

Mental health and learning disability

There were several views on the mixed economy of care. Nurses should be aware of the full range of services available, including those in the private and voluntary sector. This requires sophisticated networking and referral skills. Collaborative relationships should be developed with key voluntary organisations such as MIND and MENCAP; the stereotype of the voluntary sector as consisting of unqualified carers is a view that should be challenged. Nurses could play a key role in monitoring standards across voluntary and private sector provision by implementing quality assurance procedures. The voluntary sector was seen to be stronger than the statutory sector in the provision of housing and counselling services. As more nurses become case managers they will have more contact with voluntary and private service provision.

Requirements for skilled practice: networking skills; collaborative working with the voluntary sector; ensuring standards are maintained across statutory and voluntary services.

Mental health

All views are included in the section above along with learning disability respondents.

Learning disability

All views are included in the section above along with mental health respondents.

5.1.15 Prevention and identification of mental illness and learning disability by primary health care services

Respondents were asked if primary health services had become more involved in the detection and prevention of mental illness/learning disability since the implementation of the Act.

Mental health and learning disability

Two contrasting views concerned with primary health provision emerged. First, strong links with primary health care services were identified, services which had been set up to assist primary health care teams in identifying mental illness/disability and providing adequate referral mechanisms. Second, there was no effective primary health care locally and specialist mental health and learning disability nurses should be formally attached to the primary health care team.

Requirements for skilled practice: assessment skills and use of instruments; identifying unmet need; collaborative working with primary health care teams (referral, joint assessment and planning).

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Mental health

There is a need for some joint training between GPs, district nurses and health visitors. Respondents reported that GPs rather than consultants refer to community teams. Nurses should provide training on screening, referral and health promotion to ensure that less serious disorders are detected by GPs. Respondents favoured a social model of mental illness and learning disability within primary services, with an emphasis on promoting healthy community living.

Requirements for good practice: health and social needs assessment skills.

Learning disability

Nurses need to develop a clear understanding of service provision in primary, secondary and tertiary care. The view was also expressed that GP fund-holding may lead to greater integration with primary health care services.

Requirements for good practice: as for mental health and learning disability.

5.1.16 Cost effective resource management

The respondents were asked about their experience of cost effective resource management.

Mental health and learning disability

A strongly expressed view was that nurses needed training in financial management, budgetary control, audit and evaluation tools, which might be provided in joint training schemes.

Requirements for good practice: resource management; clinical audit and quality assurance skills; case and service evaluation skills; evidence based practice; establishing caseload priorities.

Mental health

Getting the balance right between being a caring professional and a cost effective manager was a major concern. Measuring the quality of service was seen to be as important as measuring final health outcomes.

Requirements for good practice: as for mental health and learning disability.

Learning disability

Value for money of services provided was of great concern. Knowledge of value and cost were seen as crucial in the provision of care packages. Another view was that nurses need an understanding of research methods so that they can evaluate and integrate research in their professional practice.

Requirements for skilled practice: research awareness skills; and as for mental health and learning disability.

5.1.17 Strategies for evaluating the service

Respondents were asked to identify local strategies for evaluating the effectiveness of services, and the impact the Act had on quality assurance measures.

Mental health and learning disability

Respondents emphasised the need for nurses to implement effective quality assurance mechanisms which would integrate standards setting with effective monitoring and evaluation procedures. Evaluation of services provided was seen as the professional worker's responsibility and quality assurance activities should focus on the process of service provision as well as analysis of costs and user through-put. There was a heavy emphasis on the need for team approaches to evaluation that include users.

Requirements for good practice: skills in quality assurance, standards setting, clinical audit and user evaluation; continual monitoring and development of services; evaluating the CPA.

Mental health

Two views emerged. First that nurses use research skills to focus on evaluating the social aspects of care rather than medical outcomes. Second that evaluation as part of the contractual requirement between purchasers and providers should focus on users.

Requirements for skilled practice: skills in critical analysis of research; implementing research findings; understanding contracting mechanisms and requirements.

Learning disability

Respondents called for more flexible methods of evaluation such as reflective practice. Nurses would do well to look to the voluntary sector which utilises creative, care-driven

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methods. Less bureaucratic procedures allow results of evaluations to be disseminated quickly so that changes and adjustments based on their conclusions can be encouraged.

Requirements for skilled practice: reflective practice skills; practice driven quality assurance measures; service review; implementing changes indicated by evaluation.

5.1.18 Knowledge of access to records and ease of access

This question concerned the changes in patients' rights to access their medical and nursing records and explored the implications for practitioners

Mental health and learning disability

Sensitive non-judgmental record-keeping which ensures confidentiality and care in drawing conclusions from medical records was a strongly held view. Nurses need to be aware of the issues of empowerment and accountability in record keeping. The CPA provides an opportunity for patients to be given information and to participate in their care. Respondents called for greater partnership with users in record keeping together with greater accountability and openness by nurses. There is often no formal system of information provision which leaves users unaware of their right to scrutinise their records. There was some concern about access to sensitive material and the need to review what information should be given to the public at large.

Communication and record-keeping across the statutory and voluntary sectors, and effective working with advocacy services were raised as problems.

Requirements for skilled practice: recording and note-taking skills which are objective and factual; maintaining confidential records; skills in multi-agency record-keeping; integration of users' views in the case record; understanding the implications of the Data Protection Act and other relevant legislation for record keeping; exploring values regarding patients' right to information.

Mental health

Certain issues need to be clarified regarding access to records by disturbed users; in certain cases access can be detrimental to the user's progress. Although the CPA has clear guidelines on access to information, individual services may choose to implement provision in different ways. Problems in inter-agency working were also identified where agencies may be reluctant to pass on vital information; this was a particular issue with respect to violent users and what people need to know.

Requirements for skilled practice: exploration of values and decision-making regarding access to information; using interdisciplinary records; confidentiality of records.

Learning disability

Users and carers should hold their own records. If they are unable or unwilling to do so then the question of where to hold information arises.

Requirements for skilled practice: as for mental health and learning disability.

5.1.19 Care planning

Users and carers were asked their views on the value of the care plan.

Mental health and learning disability

Users and carers were usually unaware that care plan existed. They should be fully and explicitly involved in care planning and have access to their records.

Requirements for skilled practice: user/carer participation in care planning and review; commitment to user empowerment; commitment to records that are open to users.

Mental health

Respondents emphasised the importance of involving the family in care planning and the value of collaboration and consultation, particularly when assessing risk to users and others. Collaboration in care planning also requires the nurse to give information regarding appropriate services so that users/carers may participate in decision making about their care from an informed basis. Also emphasised was the importance of inter-agency communication regarding the plan of care.

Requirements for skilled practice: networking and inter-agency collaboration skills; knowledge of local services; risk-assessment skills.

Learning disability

Access to care plans and participation in care planning leads to greater understanding of the range of services and the reasons why certain services may not be available. The outcome is more likely to be satisfaction with the care provided.

Requirements for skilled practice: as for mental health and learning disability.

In the next section we move on to consider respondents' views on areas of service provision and their requirements for skilled practice other than implications of the NHS & Community Care Act.

5.2 IMPLICATIONS OF OTHER ASPECTS OF SERVICE PROVISION FOR MENTAL HEALTH AND LEARNING DISABILITY NURSING PRACTICE

5.2.1 Models of care

Respondents were asked for their views on the model of service delivery used and any advantages of alternative models.

Mental health and learning disability

A strong view was that whatever model or approach to care is required by users, cohesive, on-the-spot inter-professional teamwork is a pre-requisite for effective care and enables open access and referral. Respondents highlighted the importance of creativity and innovation in developing and testing models of service delivery. Adopting one model of service provision was seen to be inconsistent with the flexibility needed by client-led services to meet client need. Different models were favoured characterised by one or more of the following:

- blurring of professional roles between nurses and social workers
- distinct and separate roles for nurses and social workers
- blurred role boundaries between residential and community based nursing staff
- case management in which individuals are drawn from a range of disciplines and are responsible for assessment, planning and supervision of care plans
- CPNs jointly appointed to social services departments and health service multidisciplinary teams
- learning disability clients living at home with support workers.

Requirements for skilled practice: knowledge of the range of services currently available; critical appraisal and research awareness skills; cohesive inter-professional and multidisciplinary team working.

Mental health

Respondents argued that users should be closely involved in exercising choice and running services. Multi-professional teamwork may exclude the user from decisions about who is best able to manage their case. Another view was that inter-professional working is a myth with most services taking a single-professional working style with doctors maintaining control. One view argued that all models should seek to help the individual practitioner work independently and autonomously. Another suggested the best models of service have a good balance of all types of staff and are not overwhelmed by disproportionately large numbers of nurses. It was also argued that the contracting process is forcing disciplines to define what they do. This encourages fragmentation of existing services rather than integration.

Requirements for skilled practice: critical appraisal of different models of care; autonomous, specialist practice; enabling user-participation in assessment and planning care.

Learning disability

Specialist learning disability health care teams run the danger of stigmatising users and restricting their access to mainstream services. Student nurses in training benefit from being exposed to a range of service delivery models.

Requirements for skilled practice: empowerment skills; assessment of social and leisure needs; an understanding of ethical dilemmas facing community practitioners working with people with a learning disability.

5.2.2 Multidisciplinary working

Workers and managers/other professionals were asked for their views on their work in relation to other health care professionals. The focus was multidisciplinary working, in particular: the benefits to working in this way to client care, how multidisciplinary working was developed and why, and the difficulties of multidisciplinary working and how these were tackled.

Mental health and learning disability

Good communication was seen as an important tool for solving problems whereas poor communication can lead to resistance to change or slow things down when working with other agencies. Networking is important so that nurses keep up to date with developments in other services. Collaboration benefits multidisciplinary working by speeding up access to other professionals, promoting continuity in care between staff and reducing duplication. Territoriality is avoided and the broad approach empowers each team member. Skills are pooled and client assessment is not fragmented.

Many management issues were raised: the need for services to be client-led rather than financially-led, the importance of continuously re-prioritising workloads, the need for strong leadership and recognising that liaison work takes time. Structured policies and procedures help solve conflicts between disciplines. It is important for professionals to be led by their own discipline, even if the manager is outside the team, but there must also be a team manager to avoid loss of cohesiveness between team members. A strong leader anticipates problems that can arise when some professionals are managed from outside the team.

Multidisciplinary working can clarify responsibilities of each team member but nurses need a clear understanding on this. Loss of professional identity can occur if there is confusion between what is health and what is social care. Professional supervision is important for each member to avoid a sense of isolation and defensiveness. Role blurring can lead to inefficiency if practitioners from one profession undertake tasks that can be done more efficiently by another professional (e.g. nurses doing financial assessments instead of social workers). The result can be that skills specific to one profession are devalued.

A major benefit of multidisciplinary working is the variety of skills available for client care. This repertoire of skills is located in one place which makes it easier for users because they do not have to trek from place to place to see different professionals; instead, the skills are brought to them. This point was particularly important to learning disability staff.

A benefit of multidisciplinary working is its educational function. Working with other professions enhances knowledge and keeps nurses well informed. Non-nurses value the opportunity to be informed by nurses about side effects of drugs. Users benefit in being cared for by a knowledgeable team.

Defensive relationships can damage inter-professional working. The cultural background of different professions - e.g. nursing and social work - can evoke misunderstandings and conflict. Collaborative team working succeeds when individuals develop a sense of belonging and collegiality towards the team as well as retaining their specific professional identity. Without this collaboration, single representatives of a profession can feel isolated and alienated.

Inter-professional working can empower all team members to challenge each others' views about best care practices. It is essential for nurses to have research knowledge and skills so that they can debate competently with professionals from other disciplines. The

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pooling of thinking that comes from inter-professional team working helps people to think through new ideas and come to creative solutions.

Requirements for skilled practice: multi-professional teamwork skills (i.e. respect for team members, flexibility, problem-solving, networking, negotiation and assertiveness skills, written and verbal communication skills); recognition that interviewing and listening skills that are not the same as assessment skills; research based knowledge and skills; ability to prioritise caseloads.

Mental health

All views are included in the section above along with learning disability respondents.

Learning disability

Inter-professional team working should lead to a holistic approach to user care, although collaborative working can present a problem of coordination when a large number of team members work with the same user. Disagreements between professionals from different disciplines can cause problems. For example different messages from professionals to a family can destroy a client's progress. The benefits of teamwork can be over-played. Professionals can spend too much time carving out territory or reacting defensively. Good team working, with clear role definition and multi-professional support, is a function of good management rather than of interdisciplinary working.

Requirements for skilled practice: effective liaison skills; collaboration and problem-solving skills.

5.2.3 Who the respondent works with most of the time

In seeking further information on multi-professional working, workers, other professionals and managers were asked who they worked with most of the time. Mental health respondents came into contact mostly with doctors, other nurses, other professionals and managers. Learning disability respondents had more contact with other professionals than with doctors.

Requirements for skilled practice: see requirements under multidisciplinary working (Section 5.2.2).

5.2.4 The future of service provision

All respondents with the exception of users/carers were asked for their views on the likely future developments in their service over the next five years and to describe the implications of these changes for the future of mental health/learning disability nurses. In addition to service developments considered likely to occur, we include here developments that were considered desirable and towards which services should strive.

Mental health and learning disability

The role of local authority social services departments as lead providers of services was seen to have major implications for nurses. Nurses were perceived as having to carve out specialist roles in these services, which would address aspects of both health and social care.

Respondents emphasised the importance of service providers demonstrating cost-efficient services which meet user requirements if they are to survive in an increasingly competitive health market. The development of case management as a means of managing resources to best effect was seen as crucial. The implication was that nurses will move away from direct care of clients to take on roles as case managers and initiators and developers of services. They need to be market oriented; to be able to identify gaps in service provision and take the initiative to develop services to meet them. This view highlights the perceived trend towards increased emphasis on community based services at the expense of residential care provision. The importance of nurses understanding systems of care delivery, in particular the links between residential and community services was emphasised.

One view highlighted uncertainty about the future orientation of services and the need for nurses to maintain knowledge and skills which receive little emphasis in social care oriented services, but may be crucial in more illness oriented services. Respondents remarked on a trend towards genericism in community teams and emphasised the importance of nurses recognising and valuing the biomedical traditions of the profession.

Respondents identified an expanded role for mental health/learning disability nurses as a feature of future services. Taking on some medical tasks and some of the work of clinical psychologists (e.g. psychological assessment and planning, implementing psychological interventions) were seen as areas of likely expansion.

Other views were: the importance that should be given to health education and illness prevention and the role of nurses in these spheres; the value and need for more community out-reach programmes being developed in consultation with service users so ensuring their relevance to need; the challenges involved in delivering services to homeless users and the need for training to meet these; the importance of health care personnel understanding the role of others.

Requirements for skilled practice: case management; marketing skills; understanding the implications of legislation for professional roles and responsibilities; delivery of efficient research-based interventions and services; skills of assessment, planning, monitoring and review; specialist therapies; user participation; quality assurance skills; knowledge of biomedical and social models of mental illness

Mental health

Respondents acknowledged the emphasis given to priority user groups, in particular those with challenging behaviour or long-term mental health problems, in shaping future services. Strengthening links between specialist and primary health care services was seen as a likely and desirable development with positive benefits for cross-professional/agency communication.

A broad view relates to the importance of users being encouraged to express their views and make choices about their care and services, and services being individualised to meet these requirements. Services being increasingly culturally specific were highlighted as being desirable and probable. A recurring example was of clients choosing the gender of their key worker. Advocacy services for users was seen as increasingly important.

One view questioned whether, in forming a partnership with service users, nurses should be the profession to deliver direct care. The future role of the nurse is to assess and plan care in partnership with users rather than be direct carers.

Mental health respondents also highlighted the importance of research based practice. Nurses need to understand principles and practice of research to a level relevant to their role.

There was a call for nurses to have a good grounding in the legislative basis of care and its operation in practice. The provisions of the NHS & Community Care Act and supervision orders were singled out as particular areas of deficit. Another view called for mental health nursing breaking links with general nursing and allying itself strongly to counselling and social work. Models of service development for the care of long-term mentally ill people require clarification and development as does the role of the keyworker community psychiatric nurse who was perceived as having increased responsibilities but little authority.

Nurses must be aware that community care will always be dominated by consultant psychotherapists and rehabilitation specialists and they need more clearly defined models for long-term mental illness. Some respondents expected major developments over the next five years in both rehabilitation and psychotherapy services. Others thought that nurses should concentrate on assessment from a hospital base and then decide on the appropriate community service involvement which will redefine their role with both consultants and social workers.

It was suggested that drug and alcohol services will be limited by changing funding arrangements which mean that short-term detoxification programmes are developed but longer term provision will be neglected. Another view suggested services will rely increasingly on unqualified workers since the more highly qualified nurses become the less likely they will want to be involved in day-to-day care. It was further argued that services providing long-term support for anxious and depressed people will be needed to prevent increased admission rates to hospital.

Requirements for skilled practice: inter-agency liaison; user involvement and advocacy; clinical skills to work with users with long-term mental health problems; psychiatric liaison skills with the primary health care team; effective networking with specialist services; ability to ensure user participation and culturally sensitive care; ability to work with advocacy services; supervision of support workers.

Learning disability

In addition to the views above specified along with mental health respondents, the benefits of standards setting, audit and service development to users and service providers were emphasised.

Requirements for skilled practice: quality assurance and audit skills.

5.2.5 The developing role of the mental health and learning disability nurse

Respondents were asked for their views on the likely future development of the role of learning disability and/or mental health nurses over the next five years.

Mental health and learning disability

They emphasised the importance of nurses finding distinctive roles both as individuals and as a professional group within the mental health and learning disability services. Nurses need to be flexible and adaptable and challenge existing territorial boundaries. They may relinquish some traditional skills and responsibilities and take on others. Nurses assuming responsibility for health related aspects of care was highlighted. An understanding of how the service works and the roles and responsibilities of other occupational groups and individuals was seen as important as was specialist preparation in health assessment and promotion.

Highlighted was an trend towards increasing clinical specialisation by nurses who would act as consultants to other health care workers. Examples include working with people who exhibit challenging behaviour, or mentally disordered offenders.

Both specialisms pointed to the relative isolation of nurses from the work of other health care groups. They stressed the need to build bridges with other workers, to network with other groups and services, in particular primary health care services, and to take on roles as coordinators of care. A trend towards relinquishing direct care to other workers and developing supervision skills and those of care and case management was emphasised.

One view suggested that generic nursing is likely and desirable because it will allow nurses to concentrate on assessment. On the other hand, some argued that generic training is likely but undesirable since it constitutes a major threat to the status and role of mental health and learning disability nurses. Another view argued that ward nurses should have a range of assessment skills suitable for a wider range of client types than has previously been the case. Others argued for reducing health care resources which would effectively prevent nurses developing and using specialist skills since they would be overwhelmed with routine care of large numbers of clients being maintained in the community.

Requirements for skilled practice: teamworking and networking skills; specialist clinical skills; case management skills; supervision skills.

Mental health

Highlighted here was the important increase in the supervisory role of mental health nurses in the light of increasing numbers of unqualified and vocationally trained support workers. This view has implications for the likely and desirable re-allocation of work and responsibilities for members of the multi-professional health care team - in this case mental health nursing and social work. It was thought desirable and likely that mental health nurses will move beyond an exclusive concern with health towards a wider role which incorporates elements of the current social work role (e.g. family therapy, group work, behaviour therapy). The aim of nursing is holistic care of users within their community.

Respondents anticipated the development of generic pre-registration nurse education programmes. Fears were expressed that this would result in de-skilling and leave nurses unable to make a distinct contribution to care valued by other professional groups. Decreased opportunity for specialisation was perceived as a likely consequence of a generic pre-registration educational model. This, in turn, will make nurses unattractive to employers and thus less marketable.

Another view called for an increase in the links between mental health nurses and primary health care teams rather than specialist teams and psychiatrists. This was seen as desirable because it will increase nurses' responsibilities and tie nursing more closely with community rather than hospital based care. It was suggested that mental health nursing is in decline in community care settings because the nursing role is being taken over by other occupational groups. Respondents saw the only secure base for nursing being in secure care provision within institutions. Another view that contradicts this view was that it is likely and desirable that mental health nursing will increasingly abandon its traditional custodial role.

Requirements for skilled practice: clinical supervision skills; management skills; ability to assess and coordinate health and social care; specialist therapeutic skills.

Learning disability

Respondents singled out illness and handicap as a central concern of learning disability nurses. The increasing importance of care and case management as a key role was noted. It was argued that this would require nurses to take on supervisory and managerial work but not at the expense of their professional skills. The nurse's role in strategic planning requires an understanding of information technology, outcome assessment and contracting.

Requirements for skilled practice: empowerment skills; health oriented care skills; specialist therapy skills; managerial and supervision skills; care of physical and social needs; case management skills.

5.2.6 Perceptions of the work of nurses since the community care reforms

Members of professions other than nursing (doctors, therapists, social workers, managers and purchasers) were asked for their views of nursing work since the community care reforms. We wanted to know whether the traditional role of the nurse (whatever that may be) had been retained or whether aspects of the role had changed or disappeared.

Mental health and learning disability

Respondents underlined the need for nurses to understand the principles of social work so that their care of clients is more holistic. Specifically mentioned was knowledge of clients' liberties and rights, and viewing clients as purchasers of their own services.

Nurses were seen to have an important role as therapists in specialist areas, such as rehabilitation of chronically ill psychotic patients, anxiety management, behaviour therapy, psychotherapy and counselling. They may need to specialise to ensure competence and remain up to date. The importance of retaining medical knowledge, particularly physiology and anatomy, as part of the nurse's knowledge base was emphasised. Clients often have physical as well as mental difficulties and the nurse is usually in the best position to give prompt and effective care. But nurses are having to provide a great deal more practical help to clients. They feel they are treated like support workers rather than specialists.

One view expressed was that nursing has changed hardly at all since the community reforms and the NHS & Community Care Act. The role and responsibilities remain as they were before the Act. Others saw profound changes in that nursing is taking much more of a management and supervisory role. For example, community psychiatric nurses were seen increasingly as care workers with responsibility for care management and coordination. Community psychiatric nurses were seen more appropriately employed as generic community carers unless they can define and justify a clear nursing role.

Other views were: nurses have a major role in identifying unmet need of individual clients and local populations; nurses are important advisers to other professionals, particularly social workers who do not have a health or medically related background; nurses are seen as the professionals responsible for monitoring client safety. They need a sound knowledge base and skills in managing clients whose safety is jeopardised through illness and disability.

Responsibility for care management and assessment has been passed to nurses which has given them the power to take on the social work role. Respondents noted that designing care packages takes up a lot of administrative time for nurses and adds to their workload. Many community psychiatric nurses are unhappy with the change in emphasis to long-term, chronically ill people. CPNs want to continue to look after short-term clients who need counselling.

One view was that contact between nurses and occupational therapists had increased and had led to a better, collaborative working relationship. Close interdisciplinary working is essential in community care and has to be clearly articulated for workers who operate alone, otherwise cooperative colleagueship becomes ineffective rhetoric. It was argued that intervention by hospital medical consultants is decreasing and this trend will continue. Nurses will become less dependent on medical consultants and will consult more widely, in particular with GPs and health commissioners. Disagreements between health and social services about the role of the nurse are likely to increase. Nurses are in a good position to define their contribution and to ensure the boundary between health and social care operates seamlessly.

Three final views included first, a call for nurses to understand how the internal market and its financial implications work so that they can work proactively in selling their expertise within a competitive environment. Traditional values of nursing and educational programmes have not emphasised the competitive culture of the market place. Without this, nurses cannot compete and their contribution to health and social care provision will diminish. Secondly, there was the view that nurses receive better training than social workers. They are better able to get on with the job and can attend to clients' mental, physical and environmental needs. Thirdly, it was argued that nurses need to be taught communication skills so that they can communicate effectively with clients whose physical condition makes this difficult.

Requirements for skilled practice: holistic health and social care skills; specialist therapy skills; management of physical and social needs; identifying unmet need; case management skills; inter-professional working; communication skills.

Mental health

Now that nurses are based more in the community than in hospital, they require skills that will ensure effective discharge planning and continuing care - the Care Programme Approach. They should be prepared to act proactively to prevent crises by involving other professionals and agencies early on in an event. It is important that nurses understand the practical and legal consequences of their actions.

Nurses have to cope with an extremely heavy workload without adequate support. There is an urgent need for support groups for nurses to help them cope. Other professionals in the field have access to support groups but not nurses.

One view called for nurses to take a lead role in managing the client who has a severe drug reaction (e.g. collapsing after an injection). A sound knowledge base on the action, dosage, administration and side effects of drugs is essential together with knowledge of effective intervention and prevention. The view was expressed that the community care reforms have not seen an end to the 'revolving door syndrome' in psychiatric hospitals. Implications for practice are that nurses see their expertise as lying in preventive as well as therapeutic care and education programmes must prepare them for this. There was a view that mental health care remains hospital based and so nurses need to retain their expertise in managing patients in hospital.

The Care Programme Approach was seen not to be working because of lack of collaborative effort between health and local authorities. Nurses in hospital and the community could be influential in cementing collaborative links between health and social care agencies if their training equipped them for this. Another view argued that confusion exists over who should assess clients. Nurses seem to regard it as the responsibility of the lead agency, that is, the local authority. The view was, though, that this is a nursing responsibility and it is essential that nurses do not shirk their responsibility through lack of confidence.

Other views: CPNs are now having to work more with chronically ill patients than with the acutely ill; counselling is performed better by counsellors than by CPNs; nurses should act, much more than they used to, as advocates to clients, particularly when engaging with social services departments; nurses have a responsibility to ensure close liaison between hospital and community staff when clients move in either direction; the responsibility that goes with working alone has been difficult for nurses to accept. They need preparation during training for independent decision making and accepting responsibility, and also a willingness to take this responsibility.

Requirements for skilled practice: CPA skills (ability to assess, plan and review care); multi-agency crisis intervention skills; knowledge of drug therapies.

Learning disability

Community mental health care teams need to develop into centres of excellence for clients with special needs. The teams will purchase care directly from community psychiatric nurses and social services providers. Thus, nurses will belong to the teams as

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specialists. It follows that they must be willing to accept the responsibilities of a specialist.

Other views included the ability to assess unmet need, risk assessment and management, monitoring side-effects and management of severe drug reactions, ability to take a lead role in health and social care collaboration, acute and intensive care skills for in-patient services, specialist communication skills for people with multiple handicaps.

Requirements for skilled practice: specialist therapy skills; need- and risk-assessment and management; specialist communication skills; negotiation skills.

5.2.7 Reasons for finding staff helpful/less helpful

Users and carers were asked how helpful they found nursing staff. Many views were critical.

Mental health and learning disability

Clients and carers told us that it would help them if community nurses got involved in things like filling in forms which can be difficult. Student nurses were seen as helpful because they talk to clients, take them out for walks etc. They were perceived as caring.

Another view argued that greater understanding of psychiatric care in the early phase is important; one carer stated that when her daughter was taken off to the ward, she was given no explanation. No one asked her if she was all right, if she needed any help to get home, or a ring to let her know when she could bring her daughter's clothes in. She went home to an empty house 'feeling really awful'. More thought should be given to carers' needs.

Carers' knowledge of the client, particularly when the client has drug allergies, is ignored by nurses; there is a lack of concern about the individual. Nurses seem to want to deal with the mental health problem, get the person sedated and under control without giving the patient the respect they deserve. One carer remarked that, in the case of a client with a dual learning disability/mental health diagnosis, mental health staff did not liaise with learning disability staff. This occurred even though the two groups of staff worked in close proximity and the client's learning disability nurse had told the mental health staff that she would like to be involved and go to review meetings. One respondent saw social workers and the social services being of no help to clients and carers.

Other views were as follows: client behaviour improves when carers are involved in discussions on treatment and medication; problems of over-medication occur; foster placements had proved unsatisfactory with anti-social behaviour developing and concerns over social services and foster parents handling clients' savings; clients can slip into petty crime; nurse counselling is effective; and the shortage of staff means that physiotherapy, occupational therapy and music therapy services are cut.

Requirements for skilled practice: welfare rights skills (advising, filling in forms, letter writing); involving user in planning services; information giving skills; inter-agency liaison; counselling; therapeutic skills.

Mental health

The current policy that the client should be able to negotiate with community psychiatric nurses over medication - if clients don't like it they are now allowed not to take it as long as they continue to see their CPN - is not always practised. Clients say they are given no choice on what drugs they take; the psychiatrist decides. CPNs need wide knowledge of the support services available so they can advise clients accordingly. In one case, for example, the nurse did not tell the carer about a carers' support group available to her.

Other views included the following: personal difficulties with members of staff had caused problems; travelling to a remote hospital to receive depot injections is expensive and time consuming and could be given at home; having recently been allocated a CPN rather than hospital care was a big improvement; hospital care is too brief, patients are discharged too quickly and are likely to relapse as a result continuity of staff is important;.

Requirements for skilled practice: negotiation skills; offering choices to users; understanding services and facilities; skills in working with drug/treatment non-compliance.

Learning disability

All views are included in the section above along with mental health respondents.

5.2.8 Experiences of care: advocates' perceptions

Advocates were asked for their perceptions of their clients' experiences of care provision. The questions focused on their perceptions of the clients' needs, strategies through which the service enables clients to meet their needs and expectations, and the main problems that prevent their needs and expectations being met.

Mental health and learning disability:

Advocates of mental health and learning disability clients emphasised the importance of nurses understanding the advocacy role if they are to take it on. Advocacy goes beyond the normal job specification of nurses and so they need help and information from outsiders in order to serve the client adequately. It is important that they do not rely solely on information from clients' informal carers; their information may be biased because of a hidden agenda which may not be in the client's best interests. Whether nurses should be advocates was regarded as a moot point.

Requirements for skilled practice: ability to work with advocacy services and recognise advocacy issues within the nurse's role.

Mental health

Nurses must appreciate that users have a view about their needs, problems and care. They are not always heard. The good nurse pays attention to the 'human element', listens carefully to clients and conveys the impression that nothing is too trivial. In particular, understanding and attending to alleviation of fear is paramount.

It is important to the welfare of clients that nurses are able to create a relationship of trust with clients early on so that they can discover the client's problems from the start. Creating trust requires perceptiveness, sensitivity, equality and constant vigilance to ensure continuing success; trust is often fragile and easily broken. Managers and staff cannot always empathise fully with clients, whereas advocates who are ex-users are able to understand the client's needs and difficulties to a much greater extent. Workers without professional training, such as advocates, are more likely than professionals to appreciate that people have choice in what happens and also the right to fail. Staff should not be critical of temporary lapses in clients' progress and compliance to treatment.

Advocates are a precious and scarce commodity. Lack of advocate time and funding are problems. Most are part-time, some are paid, others are volunteers. Nurses in case manager positions need to find ways to reduce advocates' workload so that they are used to the greatest effect; that is, they are free to spend their time with clients directly. One solution is to use other agencies as much as possible. For example, use DSS officers to help clients fill in benefits claim forms. Another solution is to recruit more volunteers as advocates to the service.

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One advocate raised the important point that sharing information is a key to empowering users. Nurses were seen as poor at sharing information. They need to learn how to be open with clients and how to involve them in their care. The importance of involving users in their care cannot be overestimated.

Another advocate was critical of what she saw as nurses' allegiance to just the medical model of care. Nurses need to learn and apply other models when appropriate. For example, social models of oppression and deprivation, and psychological models which incorporate the family into the care programme.

Nurses need to understand the key worker role and be able to operate as key workers with clients. they need to demonstrate a thorough understanding of all the services available to benefit clients. For example, dealing with clients' benefit-related problems requires nurses to access the local benefits agency and persistent networking with a range of agencies. Nurses should know how to get information and how to network.

Requirements for skilled practice: ability to empathise accurately with client's needs and establish relationships based on trust and respect; open and honest communication with users/carers; ensuring user/carer participation in care; use of social and health model to underpin practice; keyworker skills; networking and liaison; knowledge of legislation.

Learning disability

Advocates maintained that untrained care assistants tend to have unrealistic expectations of clients' ability. For example, a care assistant tried to give a profoundly disabled woman, with a mental age of 5 years, choice in deciding whether she wanted to go to Spain or Italy for her holiday...the care assistant brought holiday brochures to help the woman choose. The advocate saw this as an example of unrealistic expectations which could be overcome with adequate training. Care assistants need training in human growth and development. Clients would benefit if nurses were actively involved in this training.

Poor relationships between community care and primary health care is a problem. The solution is more effective liaison.

An advocate described the 'them and us' status difference between care managers and care assistants that was perceived by care assistants. Care assistants have a low self image and feel ignored by managers when decisions are made. Morale of care assistants is low and they feel stigmatised by the job.

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Inflexible and inappropriate services that result in high levels of inactivity for profoundly disabled clients, for whom day centres are not appropriate, is a major problem. A solution would be for purchasers to buy an activity centre and adapt it to the needs of this client group including, for example, multi-sensory rooms. Although the large hospitals did not provide the quality of life that is possible in the community, they ensured higher activity levels than many clients now living in the community enjoy. Care providers should consider how the best parts of institutional living can be retained within community settings.

Requirements for skilled practice: management skills in mixed-skill teams (team-building and ability to recognise training needs of care assistants); primary health care liaison skills (referral and assessment); ability to work with profoundly handicapped people in the community; sensory stimulation techniques.

5.2.9 Health professionals as advocates

Advocates were asked for their views on the possible role of nurses, and other health professionals, as advocates for clients. Only mental health respondents expressed a view.

Mental health

Two contrasting views emerged. First that advocating for users is integral to the nurses' role. Nurses with good interpersonal and negotiation skills would fulfil this role effectively. The opposing view was that development of advocates as workers distinct from health professionals is important. The nurse's role would be to identify clients who would benefit from an advocate and referring them on. Advocates are part and parcel of high quality mental health services but they should be completely independent of service practitioners, a condition which effectively disqualifies nurses from an advocacy role. Advocates should be seen as a potential source of quality improvement rather than simply a source of criticism.

Requirements for skilled practice: ability to work with advocates; identify advocacy issues in the nursing role.

The final two questions depart from the approach taken in reporting responses to the other questions in that these two were confined to students. We present their views on the courses they were taking. They were interviewed in groups, one group per site.

5.2.10 Advantages and disadvantages of training programme

Students were asked for their views about their courses, specifically the advantages and disadvantages.

Mental health and learning disability

Students on degree courses were enthusiastic about the specialties offered. They were able to decide early on what their branch would be, although it could be difficult to change if they found they had made the wrong decision. The DipHE courses were felt to be good when they could choose their placements in the specialty branch. Students on the combined RGN/RMN course felt there was limited opportunity for specialist training early on because of the need to cover the basis of general as well as psychiatric nursing.

Nursing placements were said to be too short. One course had 12-day placements in the branch programme. There was no time to get properly involved nor to see the results of their interventions. Short placements were also unhelpful to the client, particularly in learning disability. Where students had two days on placement and three days in college per week, they disliked the lack of continuity and found the theory taught in college unhelpful to their practice. Continuity was seen to be important on placements. By contrast, the social work placements for the joint DipHE learning disability/social work diploma course were 6-9 months long. This gave students the opportunity to get heavily involved in the work and to gradually take responsibility. On a DipHE course students felt there were not enough mental health placements in the branch; on another course they were content with the wide range offered.

Students criticised the CFP of the DipHE course because of its emphasis on general rather than mental health or learning disability nursing; case studies were 'always' on general nursing. The skills learned in the CFP were not relevant to all nurses. For example, mental health students were taught to pass a nasogastric tube which they would not do as mental health nurses; patients would be sent to the general hospital for this. The physical care of people with learning disabilities and mental health problems would be a much more appropriate learning experience. In the CFP the placements for students opting for the mental health or learning disability branch were extremely limited, so they were inadequately prepared for their branch specialty. The view was that the CFP should be reduced to one year and the branch programme increased to two.

Students felt strongly that college lecturers should be much more in evidence in the nursing placements. Some students said they had no visits from their lecturers. By contrast, a student on the joint DipHE learning disability/social work course saw her lecturers when on social work placement and was given a detailed assessment of her practice. She did not get this on the nursing part of her course; instead she was left to 'float around' not knowing which skills she was supposed to be learning and which she already had.

Mental health

Students complained that a gap exists between theory taught in the classroom and what happens in practice during placements. For example, students said they could not put the nursing models and principles of psychology they had been taught into practice in the wards because the ward staff did not understand what the students were trying to do and were steeped in the medical model. Ward staff do not know what to expect from DipHE students and feel threatened by them. Students felt that ward nurses should have more study days to update themselves on nursing models and there should be better communication between the college and the wards. In community placements in a deprived inner city area, the lack of resources for mental health services meant that students were unable to use the good practices they had been taught. There is clearly a need for better liaison between lecturers and practitioners and for more continuing education for practitioners.

Students described a course in which part of the teaching was done in the school of nursing and part in the university. There was lack of liaison between the two and the academic levels were very different; the school of nursing 'treated students like idiots' and the university 'like post-graduates'. The university taught social sciences and life sciences and the school of nursing taught skills, and it was a coincidence if subject matter linked. There were also organisational difficulties: the student group was too big making it difficult for lecturers to use seminars and small group teaching techniques, and there were few teaching rooms large enough to accommodate the numbers. The move from schools of nursing to university education should gradually iron out these discrepancies.

Students described a DipHE course that operates a client allocation system instead of practice placements. Students take a caseload of clients, with specified needs, which students find themselves. The advantages are that students work with a variety of clients in their home environment and with their families. This gives students some autonomy, extensive experience of community care, which they will need when qualified, and they are able to spend more time with clients than they would in the ward. The disadvantages are that they miss out on ward experience, especially knowledge of medications, and the view was that most of the available jobs in nursing are in hospitals (the head of this service said that the opportunities for newly qualified nurses to work in the community were almost non-existent).

The idea of client allocation is that students follow clients into the wards as well as in the community but the students did not mention this as happening. It may be that, with the emphasis on acute care in the community, relatively few clients have spells in hospital. On another DipHE course the students had supernumerary status on placements which enabled them to follow clients as they moved between community and hospital. This meant students were not tied to the ward and could get a good picture of hospital and community services.

Students on the combined RGN/RMN course felt that their RGN training gives them a good understanding of general problems that can affect people with mental illness. Many psychiatric patients live unhealthy lifestyles and their psychosomatic disorders require a sound knowledge of physical problems. In elderly mental health settings physical problems may be interpreted as deterioration in the patient's mental state. There are also advantages for general patients who have psychological needs; these are often overlooked and mental health students can help in identifying and treating them. The combined RGN/RMN training gives students a good understanding of health in its broadest sense and of health promotion. It important, we were told, that these subjects are retained in newer nursing programmes

Students felt that their college is out of date concerning happenings in the real world. College lecturers are not aware, they said, of the implications of GP fund-holding and trust status. GPs will not pay for three years of psychodynamic therapy for a client, for example. Also, the college required students to carry out an assessment of each of their clients but, because of the way the trust has organised its assessment teams, this was not always possible when interventions were short. The students' view was that the college should reorganise its course to fit in with the new organisational structure of the health service. One of the DipHE courses offered the certificate in counselling during the course which students appreciated.

Learning disability

A learning disability nursing/social work diploma student felt that the learning disability nursing course has more in common with social work, because of their similar value base, than with other nursing courses. She had much more in common with social workers than with general nurses. There seems to be a strong argument here for removing learning disability nursing from the family of nursing. A disadvantage of the joint DipHE learning disability nursing/social work diploma course is that diplomates have to choose whether they will be nurses or social workers when employed. A student who took a social work job on qualifying, regretted that she was not able also to be a nurse. It will be her responsibility to keep her nursing registration up to date but it will not be easy, she said. She was disappointed that jobs for combined skills are not available; students on this course were led to believe that they would be. If this problem is universal the future of joint courses should be reconsidered.

A national shortage of social work placements for students on the joint learning disability nursing/social work course presented problems. Throughout the course students could not be certain that their chosen placements would be available. A student described how 'frightening' this was; she wanted to do a learning disability placement in social work but, instead, only a family and children social work option was offered. Furthermore, the social work element of a combined course is taught to a higher academic standard than the learning disability nursing portion, which gives students the advantage over students on single learning disability courses. A student on a BSc in nursing and social work (learning disabilities) course felt that he had gained good practical experience in his nursing placements but did not gain much academically.

5.2.11 Aspects of courses helpful to client care

Students were asked to highlight aspects of their current course and any previous courses that they felt were particularly helpful to client care.

Mental health and learning disability

Interpersonal skills provide nurses with an understanding of worker-client relationships and behaviour. Learning when to listen and when to intervene is important. The student on the BSc Nursing and Social Work course was in the first year CFP. He felt that the skills he had needed on placements so far were communication skills, but he had acquired these skills, not from his present course, but while working with people with a learning disability before he started the course. Communication skills are essential for finding out about people's needs, yet the student's view was that they are often ignored by staff working in hospital wards.

Mental health

Getting away from the medical model and using nursing models is essential in the discovery of all the client's needs and in the provision of holistic care. Students felt that taking a holistic approach helps to ensure that nurses miss nothing in their care of clients. Nursing models that take in wider aspects of health and psychosocial care are a priority in nurse education.

Students felt that the study of psychological theory helps them become open-minded and able to perceive clients in a holistic way; their development, interpersonal relationships and their environment. Sociology helps students take a broad view of health and understand the inequalities of health and culture. Students benefit from courses that include psychology and sociology and apply it to nursing and also health and social care more widely. Counselling and therapy courses increase self knowledge which helps students to empathise with clients.

Videoed role play exercises, in which students act the part of clients and nurses, help them to learn about relating to others and the messages conveyed by body language. These skills are extremely helpful when working in different hospital and community settings.

Students taking the joint RMN/RGN course appreciated their experience in A&E departments because it provides good experience of managing medical emergencies and emotional crises. They were able to put their training in psychological care to good use and consolidate these skills. These students also felt that experience in general medical wards gave them a broad understanding of the medical problems that affect people with mental health problems. Physiological knowledge had helped one student identify a problem that an elderly client had sooner than he would have otherwise.

Students benefit from experience in acute mental health wards because of the range of intense learning opportunities they provide. They meet people with very different psychiatric disorders who are in hospital for long periods. Working with these people gives students insight into their behaviour and the effects of medication. This kind of experience is not possible in community settings because the period of contact with the client is spasmodic. Twelve-week ward placements are beneficial because the students can take increasing responsibility and therefore can learn more. By contrast, in community placements students are often observers and do not take caseloads of their own. When on 12-week ward placements, students have the opportunity to practise their skills and to learn from their mistakes.

Students regarded depot clinics as poor learning environments. They were likened to factories with a production-line for getting patients through the system as quickly as possible. There is little opportunity for students to build a worthwhile relationship with the patients.

Students valued the opportunity to learn about different services and the systems and mechanisms by which they work. Working in the voluntary sector was valuable because of the exposure to the social rather than the medical/psychiatric model of care. They found this different approach stimulating because it challenged their existing views.

A ward run along custodial lines can provide an excellent example of how not to run a ward. Students can learn a lot in poor wards as long as they are supported by teaching staff. It might be wise, therefore, not to exclude poor wards from the training circuit, particularly when such wards are a common feature in health care settings.

Learning disability

Courses on challenging behaviour are important for learning disability nurses so that they know how to manage clients with these problems. Students who had attended a course appreciated the facts and techniques they had learned for managing clients.

A student, who was seconded from his job working with people with a learning disability to a joint learning disability/social work course, described how valuable he had found an earlier course on challenging behaviour to his job. The course taught him how to instruct other staff in managing challenging behaviour. He also learned the importance of clinical supervision. He saw the essence of good supervision as evaluating people's working practices, analysing their problems and examining team working from the point of view of interpersonal relationships between team members.

Students appreciated what they had learned about care planning. When planning care for learning disability clients it is important to include all details of the person's life and evaluate the effectiveness of the care from this broad perspective. Students saw the benefits to practice of using the principles of normalisation and integration. In particular, they help nurses to encourage clients to get involved and to participate in the planning and delivery of their care.

5.3 ENDNOTE

In this chapter we have presented the findings that emerged from the interviews in the six sites. Discussion of these findings appears in the next two chapters. In Chapter 6 we draw the respondents' views into categories and themes. In Chapter 7 we underline the requirements for skilled practice and for education, and build models of education in the two specialties.

CHAPTER 6
CURRENT ISSUES FOR MENTAL HEALTH AND LEARNING DISABILITY NURSING

This final chapter of our findings draws together the views into 20 categories which summarise the major issues facing the two nursing specialties as described by our respondents in the sites. Details of the raw data are in Appendices 5, 6 and 5a Here we discuss these categories under seven themes and in so doing we draw upon our reflections on nurse education in England in the light of our valuable discussions with key informants throughout the course of the study. The analysis procedure is described in Chapter 4 and the themes and their contributing categories are listed in Appendix 7.1. Requirements for nurse education are raised here and specified in Chapter 7.

6.1 THEME 1 WORKING WITH OTHERS

This theme addresses issues related to working with other health or social care workers who receive services from community based multi-professional teams. It comprises two categories.

- Cat 1 Responding to the demands of multi-professional teamwork
- Cat 8 Networking

Cat 1 Responding to the demands of multi-professional teamwork

There was widespread agreement on the need for effective and efficient community teams which provide needs-led rather than service-led services in that they are driven by the needs identified, rather than users being matched with whatever services are available. To this end respondents emphasised the importance of understanding the perspectives of users and carers and finding ways of involving them in moulding the shape of services and also as members of the multi-professional team in service delivery. Clinical placement within families was seen as valuable for giving students insight into the challenges and pressures of family based care. Nurses who recognise that users' desires can be as important as their needs ensure that constant innovation and change characterises high service quality.

There was agreement on the objectives of multi-professional community care teams but respondents from both specialties were sharply divided in their view of how permeable the boundaries should be between the work of nurses and others so that a needs-led service might be achieved.

One view was that nurses working in both mental health and learning disability teams, need to maintain clear professional boundaries from other workers and avoid becoming 'jacks of all trades'. They require strong professional management and a clear identity which will persuade other team members and purchaser and provider organisations of the value of their contribution. For these respondents it was important for mental health and learning disability nurses to review and clarify their professional roles and for everyone involved to understand the nurse's role.

These views seem to be compatible with Rawson's (1994) 'mutual-respect' model of inter-professional working in which professional boundaries are impermeable and inter-professional work remains subservient to the original occupational role of each professional group. Shared learning was welcomed as a way to foster good professional relationships and lead to a shared view of role boundaries. However, joint-training leading to dual qualifications was rejected because such initiatives fudge the issue of what different occupational groups do and should be doing. As one mental health key informant pointed out, there should be a good reason for having two occupational groups when there might only be one.

The opposite view was that coherent services are best achieved by allegiance of nurses to the community care team, rather than to the background discipline of each professional, but with the full support of a management structure that incorporates all professional groups. For some respondents this arrangement results in equal status for all team members and minimises inter-hierarchical conflict. We follow Rawson in referring to this as the 'melting-pot' model of inter-professional working in which professional groups have permeable boundaries and there is potential for the mutual transfer of elements. Respondents subscribing to this view wanted to move beyond shared learning to joint training and dual qualifications, the produce of which is the flexible professional worker able to encompass social and health care related roles. They welcomed a broad based pre-registration curriculum drawing upon aspects of both health and social care and emphasising holistic approaches to assessment.

It is encouraging that respondents endorsed the Department of Health & Social Services Inspectorate's (1991) intention that services should move away from a service-led to a needs-led approach and this issue is discussed in more detail in Cat 11. They were divided, though, on whether a mutual-respect or a melting-pot model for nursing was the best way to achieve a needs-led service. The mutual-respect model rests upon the assumption that professional groups working together have equally impermeable boundaries. But Rawson suggests if one profession has more permeable boundaries than another then it may be vulnerable. Any areas of overlapping work are likely be absorbed by the more intransigent professional group and the more permeable professional group may be absorbed as a sub-set of its more powerful rivals. A number of our respondents expressed concern about the uncertain roles of mental health and learning disability nurses in the new care arrangements. They welcomed attempts to shore up the boundaries of professional nursing exemplified by the recent analysis of the role of learning disability nurses by Kay *et al* (1995) and the review of mental health nursing by Butterworth and his colleagues (Department of Health 1994).

For supporters of the melting-pot model attempts to define and redefine the role and boundaries of the professions is at best irrelevant and worse divisive if it leads to demarcation and inflexibility and distracts from the main purpose of team and service development. Rawson explains that under the melting-pot model differences are reduced, ignored or realigned and melded into a common purpose in which old professional groupings are assimilated into inter-professional work practices. The emergence of new meta- or pan-professional groupings is the result and certainly some of our respondents saw joint training as an important step towards a generic mental health/learning disability worker.

Shared learning may be seen as a milder version of the melting-pot model. There was widespread support for it across respondent groups, suggesting that it might also be compatible with impermeable professional boundaries; shared learning is further discussed in Cat 18. There was also considerable support for team training, again associated with the melting-pot model, in which the team rather than the individual is the focus. One respondent remarked that individual courses were limited because on return to the team there was often little scope for putting into practice what had been learned.

The melting-pot model is compatible with the notion of a 'seamless' service, much favoured by policy makers, which advocates dissolution of boundaries between professional groups. There are many examples of work being devolved from doctors to nurses but we came across few examples of blurred boundary working in practice.

Cat 8 Networking

Networks between voluntary and private agencies and with social services departments and community health care teams was seen as crucial to community services in collaborating and coordinating their approaches to provide effective support to learning disability and mental health service users.

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Building effective networks was seen as essential to nursing work within both specialties and requires careful planning and management. The development of efficient multi-agency referral strategies and the single multi-professional client record and multi-agency records were cited as coordinating mechanisms. Some respondents wanted nurses to link more closely with major charities (in particular MIND and MENCAP) and to bring them in closer contact with service planning. Another view was that these organisations are best placed to develop different services and to critique existing services from an independent stance. Nurses were perceived as needing to understand the health care market and the roles and functions of the different agencies; particularly the distinctive contribution of and funding base of the private and voluntary sector. There was support too for increased use of voluntary organisations outside the main stream NHS service for student practice placements. This was seen to have the advantage of exposing students to innovative and creative work practices which embody social approaches to care and give priority to users' views.

More effective links between primary and secondary care was highlighted as an important focus for networking activity. In particular mental health and learning disability nurses were perceived as needing to gain confidence in their role as specialist advisers to non-specialists - general practitioners, health visitors and district nurses - and also to commissioning agencies on service planning issues as well as specific clinical issues, such as the management of challenging behaviour, epilepsy and users with serious and prolonged mental illness. Nurses were seen to need skills in self-presentation, in marshalling arguments and delivering them coherently; nurse education was seen as important in helping nurses develop these abilities.

6.2 THEME 2 CLINICAL PRACTICE

This theme addresses the main issues raised by the respondents in relation to high quality clinical learning environments and procedures by which nurses[1] can be helped to learn in practice. It also includes clinical support and supervision required by nurses and support workers. It comprises three categories:

- Cat 12 Learning in practice settings
- Cat 24 Support of professionals
- Cat 17 Management and support of non-registered workers

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[1] We refer to qualified nurses as 'nurses' and to care staff, who may or may not have had some training, as 'support workers' or 'non-registered workers'

Cat 12 Learning in practice settings

This category addresses the pre-requisites of practice settings which provide positive areas for learning. Respondents from both specialties, but particularly mental health nursing, remarked that the move to a community based service is not reflected in opportunities for high quality placements. Overall, it was felt that there is still some over-emphasis on hospital placements in pre-registration mental health nursing courses. Also, that in many community placements students do not have sufficient opportunity to take responsibility for the care of individual patients. Some respondents drew comparisons with trainee social workers who were perceived to have more opportunities than student nurses to work relatively autonomously with users and to be supported in this through tight formal supervision systems. This is the main advantage of the acute psychiatric ward which was seen to provide pre-registration students with a range and intensity of learning opportunities not possible in community placements. Highlighted was the importance of students having experience of managing their own caseloads under supervision and also experience of acute and intensive care of patients in hospital. The importance of students being able to follow their clients into and out of hospital was emphasised. Students from both nursing specialties supported placements in general hospital wards and A&E departments as settings in which to learn about medical conditions and emergencies that might affect their clients.

Respondents emphasised the importance of committed clinical staff as supervisors for students to help them apply theory to practice and develop theory during the course of their practice. The current emphasis in developing reflective practitioners was commented upon favourably by several clinical staff. One suggestion which received support from both specialties is devising ways of involving users directly in assessing the performance of students on placement.

A number of clinical staff from both specialties commented that clinical placements of students in the CFP of the DipHE courses are too brief to allow skills to be learned and practised and to permit the development of supportive relationships with clients. Some supporters of a generic approach to nurse education (discussed further under Cat 23) believed this problem would be alleviated if the core training is a full three years rather than only the first 18 months. Some advocated return to apprenticeship in nurse education and suggested that an increase in clinical placement time and teaching by lecturer-practitioners, at the expense of classroom teaching, would enable apprenticeship models of education to re-emerge.

For several mental health respondents the organisation of clinical placements for pre-registration students should reflect the emphasis on the care of people with severe and long-term mental health problems. One key informant suggested a long-term placement, possibly over a one or two year period, during which time the student would monitor and support a seriously ill patient for one day each week under supervision. The informant argued that brief placements with this client group are of little value because they give students only a limited perspective on patients whose illness is likely to fluctuate over months and years rather than weeks. A further suggestion was to remove the rostered service requirement of DipHE courses to enable lengthy placements for students in settings for the long-term mentally ill such as MIND homes or in voluntary sector housing, where most of these service users live.

Some DipHE course lecturers from both specialties pointed out that they have no budget to fund placements for students in innovative services which are often outside the NHS. This was seen to unfairly disadvantage nursing students compared to students from other disciplines (such as social work) for whom a placement budget is available. Some respondents saw the anticipated drop in student nurse numbers as solving this problem, but this does not provide a long-term solution.

This category also incorporates views about the value of placements for clinical updating of college based nurse lecturers. The point made by several respondents was that the nature of services is so fast moving that, unless lecturers are personally involved in practice, their practical experience quickly becomes redundant. There was consensus that the pace of change has speeded up greatly since the move to a community based service and that knowledge of hospital based nursing has a longer 'shelf life'. It was widely acknowledged that classroom-bound nurse lecturers (referred to as 'career tutors') have become divorced from practice; this is one reason for the widespread perception that nurses' education lags behind service developments. The point made by several key informants is that lecturers teach best those issues that they are tackling in their daily work and thus career tutors no longer have a place in nursing.

These views accord with the recommendations of Butterworth and his team (Department of Health 1994) that lecturers should maintain their clinical skills by spending one day each week in clinical practice. This recommendation received support from many of our respondents although they acknowledged the practical difficulties. Some respondents, particularly lecturers, thought it unrealistic to expect lecturers to undertake clinical work as well as pursue research as is required by their new masters in the universities. Amongst promising suggestions was that lecturers could work on a sessional basis - for example, running a therapy group or taking responsibility for a very small caseload - or being seconded every three years for a prolonged and structured period of clinical updating. As mentioned earlier, increasing the number of joint appointments (education-service) received support from a number of respondents from both specialties, but several pointed to the high personal cost for the individuals involved. A key informant highlighted the importance of achieving an adequate level of service support for these appointments and the approach at Oxford Brookes University was cited as a useful model for future development.

Cat 24 Support of professionals

Concern was expressed by mental health respondents about the potentially stressful nature of nursing work and the expectation that nurses cope with a heavy workload without adequate training and support. Respondents highlighted the value of clinical support groups for nurses and the importance of running such groups and methods and modes of clinical supervision being addressed in pre- as well as post-registration teaching programmes. The views of our respondents support the Department of Health initiative to promote clinical supervision in nursing (Department of Health 1993a).

The process of deinstitutionalisation and a continued emphasis upon working with seriously mentally ill people is likely to lead to non-specialist staff becoming increasingly involved with clients not considered to be seriously mentally ill. Therefore specialist mental health nurses are likely to be called upon to offer consultative models of care to these professionals. Caplan's (1970) work on consultation and liaison psychiatry is experiencing a resurgence of interest.

Cat 17 Management and support of non-registered workers

Further to Cat 24 respondents from both specialties emphasised the management and supervision of support workers as being integral to the nurse's role in cost-conscious services in which there is increasing substitution of nurses by support workers and regular skill-mix reviews. Emphasised here is nurses having a sound clinical knowledge base from which to monitor performance of support workers and ensure high standards of work, learning to delegate whilst retaining control and accountability, induction programmes for support workers and on-the-job training to ensure that high care standards are maintained, and the importance of including support workers as full members of the multi-professional care team if their potential is to be realised.

Respondents noted that support workers are the backbone of many mental health and learning disability services but are undervalued by care managers who fail to recognise the value of the flexible approach to client care often taken by these mature workers. Respondents added, however, that support workers often have unrealistic expectations of clients' abilities, particularly learning disability clients, because they have insufficient understanding of the full impact of arrested development. Getting the best out of care workers requires assessment of their practical competence and supportive supervision to ensure that they work within their abilities. It also requires nurses to have a clear understanding of the skills of care workers and to recognise how these relate to the competencies of nurses. One respondent suggested that greater emphasis be given to support workers in the ENB 998 course on teaching and assessing in clinical practice.

In preparation for the move to include National Vocational Qualifications in the professions, the Occupational Standards Council has been established for the care sector and work is underway to decide how regulatory and awarding bodies are to be represented on it (Barr 1994). During our fieldwork and, in particular in our discussions with key informants, the relationship between National Vocational Qualifications and professional qualifications and the possible effects of this on inter-professional collaboration, was raised. Some respondents objected to the 'competence-mania' of current educational debate and raised doubts about the ability of National Vocational Qualification based education to capture the qualities of professional nursing practice. For others, in particular advocates of the 'melting-pot model' of inter-professional working (see Cat 1), the move by National Vocational Qualifications into the professions represents an integrating mechanism which will foster elements of multi-professional education, a common language, common concepts and common areas of study.

Most of our respondents reported that a professional nursing education in either specialty has much to commend it over the National Vocational Qualifications route. A main cause for concern for some is the apparent failure of learning disability and mental health nursing to recruit able support workers many of whom choose to work instead in voluntary agencies or as mental health workers in community teams. A key informant argued that mental health care and the care of those with learning disabilities is a potentially attractive job as evidenced by the very many people attracted to working in the voluntary sector, or as support workers in community mental health teams. These people are often extremely able, may be from ethnic communities and are enthusiastic towards innovation in mental health care. Although being a nurse can offer many more career opportunities than being an unqualified social worker, many people choose non-registered work in preference to nursing, and a substantial number of these people will qualify through the National Vocational Qualification route. They are not convinced that the initial qualification is really worth three years of their time and commitment. Specialised courses leading directly to a mental health or learning disability nursing qualification (and an academic qualification), rather than the DipHE programmes currently on offer was proposed as one way of recruiting this able workforce to nursing.

Several respondents singled out mature entrants, possibly people who have been made redundant and are considering a second career, as a group of people to whom mental health and learning disability nursing needs to broaden its appeal.

6.3 THEME 3 LEARNING FORMATS

In this theme we highlight aspects of curriculum content which were valued by our respondents and seen as essential to work in the new community based services of today. It comprises three categories:

- Cat 2 The foundation disciplines
- Cat 13 Lecturers and teaching
- Cat 18 Shared learning

Cat 2 The foundation disciplines

According to our respondents one of the few really noticeable effects of the NHS & Community Care Act (1990) has been the pressure it has exerted on services to separate more clearly who is responsible for what. Thus it has led to pressure on nurses to clarify their roles and their contribution to care. Future roles of mental health and learning disability nurses are discussed under Cat 23. Here we distinguish between respondents who emphasised that mental health and learning disability nursing education should adopt a broad focus to address social problems as well as health concerns faced by clients, and those who favoured restriction of the educational focus to achieving improvements in the physical and psychological health of their clients and lessening the impact of illness and handicap. These views are not necessarily contradictory and a number of respondents believed that both aspects are equally important.

The broad view revealed a close relationship between mental health and/or learning disability nursing and social work with much permeability between roles with the roots of nursing knowledge drawing primarily on the social sciences, particularly on communication theory and practice and fostering good interpersonal relationships.

By contrast the narrower view rooted nursing in the biomedical sciences. mental health respondents in this group emphasised the importance of nurses having a good understanding of psychiatry and general medicine to inform their knowledge of psychiatric assessment and treatment. This knowledge base enables nurses to contribute to medical decision making and manage the many physical health problems experienced by clients. These respondents believed that the training programmes that existed before DipHE neglected the biomedical sciences to such an extent that there is now a generation of practising nurses who are inadequately prepared to meet the general health needs of patients, particularly those with long-term mental illness.

As an example, a key informant declared that knowledge held by many mental health nurses of the newer drugs for long-term maintenance of psychotic patients in the community is so inadequate that the old depot-phenothiazines continue to be the mainstay of treatment for people with long-term mental health problems, particularly those living in the community. These drugs, we were told, are administered by nurses who have little influence on titrating doses because most nurses do not know how they work, have no interest in them and are anxious about taking responsibility for medications. Many of these old drugs have unacceptable side effects which precipitate non-compliance. mental health nurses have not played much part in promoting the newer generation of depot neuroleptics, in contrast to practice in North America where old drugs such as Haloperidol are hardly used except for short-term management. Community psychiatric nurses (CPNs) are blamed for this outdated practice, not the psychiatrists, who may see the patient only every 6 months. The irony is that the current generation of nurses, notably CPNs, see themselves as part of a new and progressive generation.

These views resonate with recent literature (e.g. Bennett *et al* 1995) which suggests that mental health nurses do not administer and monitor neuroleptic medication conscientiously. Developmental issues in this area include the emergence of anti-psychotic drugs which affect serotonin and other neuro-transmitters instead of the traditional dopamine-targeted phenothiazines. Also the use of motivational milieu and similar techniques in medication compliance groups (White *et al* 1996, Kemp *et al* 1996).

Also featured in this category are nurses who emphasised the importance of developing a clinical specialism by adhering to either biomedical or social-psychological approaches to care, to avoid being perceived as simply a 'hands off' care organiser. This suggests that Beardshaw and Towell's (1990) keyworker-extension model, with its retention of care delivery, may be more attractive to nurses than either their social entrepreneurship model which is dependent on purchasing power, or their brokerage model which is characterised by nurses performing an advocacy role. Some respondents thought that de-skilling would make nurses unattractive to service providers, particularly if (as was suggested) case/care management evolves into a specialist discipline distinct from direct client care. Specialisms mentioned refer to client groups (e.g. mentally disordered offenders, people with addictive disorders, autistic children, learning disability clients with challenging behaviour) or to specialist therapies (e.g. cognitive-behaviour therapy, cognitive-analytic therapy, psychodynamic counselling).

No consistent distinctions were made between pre- and post-registration courses except that the latter offer increased scope for shared teaching and learning with other professional groups. Post-registration courses seen as offering opportunities for shared multi-professional education included those that focused on: user groups (e.g. adolescents, dementia sufferers, people with long standing psychotic illness, people with multiple physical and learning needs); interventions (e.g. family therapy); particular aspects of care and treatment (e.g. courses on child protection); keyworking and case management (see Cat 9 for details) (e.g. joint patient assessment between health and social services, including developing joint assessment forms, written material and the structural links between health and social services departments); and courses focused on staff re-training for community care.

The competencies listed in *Working in Partnership* (Department of Health 1994) were recommended in devising pre-registration mental health nursing programmes. Also emphasised is the need for educationists to consult service providers to ensure that teaching is relevant to service needs and priorities.

Cat 13 Lecturers and teaching

This category addresses the views of respondents from both specialisms on how students should be helped to learn. Important here for many respondents was: who should be recruited as college based nurse lecturers, how they should be organised around subject disciplines, and the teaching methods found of most benefit by students.

There was agreement that the people recruited to departments of nursing within the universities should be nurses given that non-nurse subject specialist lecturers are available in the other departments across the multi-professional faculties. Also, nursing experience is needed to help students recognise the relevance of specialist subject input to their work and to draw on it in practice.

Qualities of good nurse lecturers most frequently mentioned are:

- being a graduate and preferably having a post-graduate degree in a clinical or research based subject. None of our respondents supported recruiting only nurses with nursing degrees and believed that a department with graduates drawn from many relevant disciplines produces the best mix
- competent, confident, credible and acceptable to clinical staff
- self-motivated since registration (with a background that demonstrates appropriate professional development)
- interested in pursuing clinical practice or research and not simply in teaching. As mentioned in Cat 12 continuing clinical experience and credibility was considered important but asking nurse academics to combine clinical work and research with teaching is not always feasible. The fear was expressed that this would dilute the academic credibility of nursing to the detriment of the profession. Some respondents favoured research activity being distributed widely throughout the colleges. Others thought research should be centred in perhaps 20% of nursing studies departments with the remaining 80% focusing on high quality teaching and development of clinical practice as the best way to maintain academic standards.

Lecturers were seen to need personal qualities including: charm, inspiration, enthusiasm, the capacity to be generous with their time, especially towards students, and having the administrative abilities needed to coordinate and organise courses. Few respondents believed a teaching qualification was essential but most felt that a period of probation teaching and the opportunity to develop teaching skills are an essential part of development programmes for lecturers.

Concern was expressed about the rapid promotion of some lecturers to senior posts especially in the new universities during the merger into higher education. Equally there was concern about the limited opportunities for career progression and promotion open to lecturers particularly over the next few years due to 'downsizing' and mergers of colleges of nursing. Key informants drawn from the traditional universities maintained that opportunities for career advancement have always been too limited.

One key informant anticipated a change in the pattern of appointment of lecturers to few relatively permanent lecturers supported by many on short-term contracts from clinical areas to run specific course modules.

The organisation of lecturers around subject disciplines is under constant review and a range of views was expressed. The debate is between those who favour students having a grounding in the basic subject disciplines versus a more applied approach. Advocates of the applied group were concerned that the move into higher education would mean material of marginal relevance being taught to students in an attempt to demonstrate the academic credibility of the new nursing departments. A mental health key informant objected to what she saw as the tendency of nurse lecturers to reify and transform nursing practices - what nurses do with patients - into academic subjects. She gave interpersonal skills and health promotion as examples which, she argued, are part of, and therefore should be taught as, nursing.

Also included within this category are teaching methods and it is to these that we now turn. There was support for increased attention to information technology within the curriculum of both specialties, both as a subject in its own right and also computer assisted learning for learning facts; for example, details of the Mental Health Act and other legislation, a working knowledge of which was considered essential for working in the new services.

Students interviewed gave much support to learning interpersonal and communication skills through videoed role play and feedback. Lecturers noted the importance of branch-specific seminars in support of key lectures in DipHE courses. Student-led seminars were noted by some to be in vogue. These were seen to encourage active learning by students, but a key respondent emphasised that student-led seminars are only valuable if the lecturer is knowledgeable and is able to expand on the material for the benefit of all the students, and corrects students' misconceptions.

As discussed in Cat 12, some respondents advocated a shift in emphasis from the classroom to teaching in clinical areas. The effect of new technology as a stimulus to distance learning was noted, but respondents found it difficult to predict what effect this might have in practice.

Respondents had little to say about course evaluation, although most felt that it should be multifaceted and lecturers should not simply make knee-jerk reactions to student feedback.

Cat 18 Shared learning

The issue of shared learning and joint training received much attention from our respondents and has been mentioned in other categories. There was widespread support amongst respondents from both specialties of the benefits of multi-professional education to service users and service providers and their practice. In particular shared learning was

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perceived to promote team building, policy consistency, and understanding other professional roles. Several respondents cited the advantage of pre-registration shared learning within teams and in practice settings so that knowledge of cases could be drawn upon to ensure learning is relevant to practice. Shared learning was also seen as applicable to classroom teaching with the following topics as particularly suitable: financial budgeting, management and leadership skills, legal issues, the theory and practice of research, counselling, stress management and crisis intervention.

Shared learning at post-basic level was supported across a whole range of topic areas. A key informant pointed to the challenge of shared learning for assessment strategies; in particular whether it is feasible for the same course to be assessed at different levels. If this were possible then the scope for shared learning across disciplines is much increased.

Views on shared learning, and more particularly joint training leading to dual qualifications, were influenced by respondents' opinions about the value of generically or specialist trained nurses or workers for mental health and learning disability care. We have touched on this issue in relation to models of inter-professional permeability in Cat 1 and it is discussed further in Cat 23. Some supporters of shared learning saw it as a means of creating generic workers and avoiding professional exclusivity. Others supported shared learning as long as professional boundaries are retained and nurses maintain their separate identity. Some students criticised joint learning disability nursing/social work courses because jobs for combined skills are not available, they said, and so students must decide whether they will be nurses or social workers. The main requirement for the nursing profession, and mental health and learning disability specialties more specifically, seems to continue the debate on the purposes and products of shared learning and its distinction from joint training.

A key informant suggested that the benefits of shared learning at pre-registration level could be best realised by a modular approach to DipHE training in which some modules are exclusive to nursing students and others are shared with students on different programmes and with other professionals.

6.4 THEME 4 USER ENABLEMENT AND EMPOWERMENT

This is a broad theme which includes ways of assisting users to live as normal a life as possible and exercise greater control over their lives. It also includes ways of involving users in service development, provision and evaluation and the nurse's role in relation to advocacy and risk management. It comprises four categories:

- Cat 5 Advocacy
- Cat 17 Outreach
- Cat 25 Empowerment strategies
- Cat 4 Rights and risks

Cat 5 Advocacy

There was a widely supported view that empowerment and advocacy are fundamental to the new relationship between user and nurse, the hallmark of community based care, and are not optional extras to be attached to traditional services.

A distinction emerged between respondents who saw the nurse as having a distinctive role in the multi-professional team as an advocate for users, and those who saw this role as incompatible with the nurse's position as service deliverer; thus the need for independent advocacy services to be built into the structure of the service. For the former it was considered important that nurses are knowledgeable and skilled in self-presentation so that they are able to question the decisions of other professionals on behalf of users. The latter group emphasised the benefits of independent advocacy services, seeing them not only as a services' watchdog but also as an essential hallmark of service quality. Ensuring dedicated resourcing for an independent advocacy service was mentioned by several respondents. Ex-users as advocates was supported by many respondents who saw their personal insights as an important resource.

For some mental health respondents multi-professional teamwork in some services excludes users from decision making. They underlined the importance of involving users and user advocates in running mental health services and introducing students to practical examples of how user choice and power can be exercised.

The contribution of users to teaching was reported by a number of respondents. Less common seems to be the practice of including users in curriculum development in ways which do not amount to tokenism.

Cat 17 Outreach

This category highlights the nurse's role in developing out-of-hours and other positive assertive outreach services to meet the needs of users and their families who do not actively seek help. This category emerged for learning disability respondents only which is surprising given the attention paid to developing these services for users of mental health services who are too disturbed, too resistant or too unreachable to seek help (Bleach & Ryan 1995). Valued were nurses who understood that scepticism and mistrust by users of service providers may arise from the nature of mental illness and disability and unsatisfactory past experiences. Also nurses who persisted in their attempts to engage users with services in ways which are acceptable to them. Respecting the right of users to make their own decisions whilst ensuring that those who need help receive it was singled out as an ever present issue for clinical staff.

Cat 25 Empowerment strategies

User empowerment, and the associated concept of working in partnership, is emphasised in the recent nursing literature (e.g. Department of Health 1994, Repper *et al* 1994, Butterworth 1995) on issues of service delivery and is seen as essential if users are to maintain their health and minimise their distress. Empowerment was considered important by respondents from both specialties. In practical terms it was seen to exist when users start challenging care and treatment regimes. It requires nurses to learn to help users to influence their care and treatment without invoking defensive reactions from staff. Practical assistance (e.g. help with letter writing, form filling and dealing with agencies) and provision of information on local services and resource availability was highly valued by users and carers for improving quality of life.

This category highlights the value of written records for representing the views of users and as a vehicle for involving them more closely in their care. Some users and carers reported no knowledge of a written care plan but others were involved in writing them. They reported that the record enables them to appreciate the rationale for care and why certain services are not open to them. They also identified advantages of using the records as a contract between professional care staff and themselves and their carers. Several respondents noted the ethical and legal risks if no care plans are available for scrutiny, if a case that needs investigation arose.

The record was seen by several nurses as a source of information for users about their illness, treatment and progress. This applied to respondents from both specialisms. learning disability respondents mentioned the use of symbols and pictures in records to help clients understand. Respondents pointed out that users have a right to see this information under the Data Protection Act (1984) but they saw this right rarely exercised. There was support for users holding their own records whenever possible, although some were concerned about the possible effects of this with disturbed clients. Valued was the importance of a clear written local policy on access to records together with guidelines specific to the Care Programme Approach (CPA). Ryan *et al* (1991) suggests that case management slots into CPA as a specialist service delivery system for those with particularly complex health and social care needs. However, a number of mental health respondents were unclear about the relationship of CPA and case management.

Cat 4 Rights and risks

A user-led approach to service delivery was perceived by respondents from both specialties to entail achieving a balance between risk and benefit necessary for ordinary living. This requires accepting that a level of risk is necessary for wellbeing and flexible open-minded attitudes to a user-led service. Risk assessment in cooperation with patients was seen by mental health respondents as part of helping clients to cope with crises related to their illness and promote rehabilitation. Of particular note is the importance of CPNs negotiating medication regimes with users on long-term depot medication and finding an acceptable course of action in cases of non-compliance (e.g. negotiating with the client to continue contact with the CPN when refusing medication).

Under this category we also include the importance of training in risk assessment and management, safety and break-away techniques which some nurses saw as essential training for responding safety and effectively to unpredictable behaviour.

6.5 THEME 5 RESPONDING TO THE MARKET AND SERVICE PRIORITIES

Our respondents were unable to make a clear distinction between the general trends in service provision consequent upon the move to a community based service and the specific impact of the NHS & Community Care Act (1990). However, a noticeable implication of the Act for most respondents was that all services are now operating within a competitive market and that nurses and other multi-professional care team members have to respond to market demands if they are to compete successfully for funds as providers and for recognition. This theme captures these concerns which were expressed under two categories:

- Cat 20 Service evaluation
- Cat 22 Balancing the budget

A third category - Cat 3 Priority areas for service delivery - highlights the demands placed on nurses by the need to follow national priorities for service provision.

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Cat 20 Service evaluation

The NHS & Community Care Act (1990) was widely perceived to have reinforced the need for professionals to carve out their roles and responsibilities and demonstrate that they offer value for money. Developing and monitoring the quality of service provision, striving for continuous improvement and user satisfaction, and demonstrating successful client outcomes within a cost effective service were seen as prerequisites for successful services in a competitive market.

Respondents, particularly those from a learning disability background, pointed out that living in the community may result in high levels of inactivity for profoundly disabled users compared to their previous institutional life, particularly outside conventional working hours. The solution, according to many respondents, is flexible services which aim to transfer the positive features of institutional life to the community. Requirements for education included training in therapeutic activities and service development relevant to profoundly disabled clients.

Mental health nurses were aware of the growing influence of general practitioners as purchasers of services and were concerned to ensure that they are satisfied. Clinical audit was given high priority and for nurses acting as purchasers this extended to monitoring the quality of services provided by voluntary and private agencies. Respondents from both specialties highlighted the importance of users being involved in monitoring service quality and establishing mechanisms for this (e.g. complaints procedures).

Respondents from both mental health and learning disability pointed to the difficulties of evaluating medical and social outcomes of health care without detracting from the service provided to clients. Several respondents made the point that this could only be successful if nurses are committed to research in practice and that dedicated time is available for this. Knowledge and training in research methods and how they might be used to evaluate practice was highlighted as important elements within education programmes.

Evaluation using clinical audit techniques was mentioned as a frequent and increasingly common requirement of contracts between purchasers and providers. This requires that nurses have a clear understanding of the nature of the agencies' contractual obligations and priorities (e.g. a profit motive, pressure group activity to improve standards of existing services), the purchasers' role in monitoring service quality, and familiarity with contracts and contracting. Familiarity with the social policy context and the workings of the internal market was seen as priority for education programmes and familiarity with existing models of service delivery through visits and seminars led by service managers was valued.

The perceived implication of the internal market was that nurses demonstrate their worth as individuals and as a professional group. But it is equally important for the team to be the focus of evaluation and continuous improvement. Team evaluation was seen to involve reflection on practice by individuals within a supportive atmosphere. Requirements for education included understanding how to foster reflective practice and put in place strategies for team support.

Cat 22 Balancing the budget

Nurses were seen to lack confidence in their ability to plan and manage services within a budget. Some respondents pointed out that the new services require nurses who are both caring professionals and cost efficient managers. The frequently cited requirement for education was training in financial management, marketing, audit and evaluation as components of pre-registration courses and building on these skills in post-registration studies.

Within this category we also include the concerns of some senior nurse managers and service planners and key informants of the funding arrangements for mental health nursing and learning disability nursing education. New funding for nurse education came into force in April 1995 based upon eight new regional educational committees and a variety of consortia at local level. Several respondents thought this a rational way of mobilising money to meet educational demands of the service providers but they were concerned that, unless colleges of nurse education demonstrate themselves sufficiently responsive, service employers will look to vocationally prepared personnel and create totally new jobs that do not require nurses.

With respect to pre-registration mental health and learning disability branch programmes of DipHE courses, several respondents expressed concern that existing contracting arrangements will drive down the number of minority branch nurses produced to a point at which the number of nurses is insufficient to develop the services to meet users' requirements. As to the funding of post-registration courses there was much support for the idea of the Higher Award for learning disability and mental health nurses, but its success was seen to depend on adequate funding, which in turn depends upon the success of nurse educators to persuade service managers that well trained nurses can make a difference to the quality of care.

Cat 3 Priority areas for service delivery

This category contains themes which highlight the demands on nurses imposed by national priorities for services. For mental health respondents the priority of services for people with serious and persistent mental ill health (Department of Health 1992b, 1994) means that all specialist nurses must receive training for supporting this user group and non-specialist staff working in primary health care teams. In the literature no consensus has been reached in defining this group but our respondents reflected a general view (e.g. Ford 1995, Gournay 1996) that these individuals will be predominantly psychotic with resulting long-term disabilities. For some respondents the care of this group of patients, the ability to 'stay with them', to successfully manage their disturbed behaviour throughout the fluctuating course of their illness, and to motivate them is the heart of mental health nursing. The Thorne course on psychosocial and behavioural approaches to the care of long-term seriously ill people, run by Manchester University and the Institute of Psychiatry, London University, was mentioned by several respondents as a blueprint for future post-registration courses at first degree or masters degree level. For learning disability respondents a similar case was put for services for people with multiple disabilities and this was seen as an important impetus for future curriculum planners.

Respondents from both specialties pointed to the priority now given to providing ethno-sensitive services for users. Targeting these services successfully and in a way in which discriminatory and/or oppressive practice is avoided requires nurses who have undergone racial awareness training that highlights the ubiquitous nature of racial prejudice and how it can be countered. These nurses also need to understand the cultural and ethnic similarities and differences within and between ethnic groups, the meaning of learning disability and mental illness within different cultures, and ethnic minority cultural influences as they affect daily life. These issues were seen by a number of respondents as a priority for nurse education.

Another priority for both specialties was services to unpaid carers living at home. Keeping these people fully informed of the aetiology of the client's ill health and treatment programme and means of managing disabilities was seen as an important aspect of family support, together with helping them manage the anxiety and stress of caring.

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6.6 THEME 6 VALUES

The values held by nurses were identified by respondents as important foci for education because they have an important effect on the quality and tone of services provided to users. These values are touched upon under other categories, but receive particular attention here. Two categories contributed to this theme:

- Cat 19 Values underpinning care
- Cat 7 Therapeutic allegiances

Cat 19 Values underpinning care

Toleration and open-mindedness to the ways in which people live and accepting alternative lifestyles which do not constitute a threat to health were singled out as the main values which pre-registration education programmes should seek to promote in students. Several mental health respondents pointed to the impact of social factors on quality of life of people with mental health problems and looked to education programmes at pre- and post-registration level to address the dynamics of health and social factors and the ways that these might promote healthy living.

Cat 7 Therapeutic allegiances

Mental health respondents identified allegiances of nurses to schools of therapeutic psychology (e.g. behaviourist, psychoanalytic) as sources of theoretical enrichment but also as potential sources of conflict which have weakened mental health nursing as a specialty. Several key informants argued against what they saw as a the tendency of some nurses to undertake post-registration courses and use these to divorce themselves from nursing. Nurse behaviour therapists, who also call themselves behavioural psychotherapists, and nurses trained in psychodynamic psychotherapy, who call themselves psychotherapists (nurse having been dropped from their title) but practice as such under the auspices of the UKCC, were given as examples.

6.7 THEME 7 THE IMPACT OF NEW MODELS OF CARE AND FUTURE DIRECTIONS

A large proportion of respondents from both specialties pointed to the need to set education for the two nursing specialties against the backdrop of new ways of delivering services to clients. The identification of client groups as priorities for service delivery has already been discussed in Cat 3. Here we cover the views of respondents on assessment of users, the requirements for education of case and care management and different levels of client support, and the future direction of the two specialties.

Three categories contributed to this theme:

- Cat 11 User assessment
- Cat 9 Case/care management and different levels of user support
- Cat 23 Genericism and specialism and the future of the mental health and learning disability specialties in nursing

Cat 11 User assessment

Assessment is an important topic under the new care/case management arrangements and was often referred to by respondents from both specialisms as a key skill and a prerequisite for the delivery of appropriate user-centred services. In this category we take a broad approach to user assessment to include setting objectives and priorities, considering user responses and interventions and services, determining eligibility and agreeing plans to meet needs identified. Assessment can take place at a number of levels. Some respondents focused on assessment at the time of user referral, others discussed comprehensive assessments carried out by specialist staff (e.g. care managers, Care Programme Approach keyworkers, intensive community support workers) which are likely to be used for only the most complex cases.

The Department of Health & Social Services Inspectorate practitioners' guide (Department of Health & Social Services Inspectorate 1991), which refers specifically to care management and assessment, points out that few practitioners make a clear distinction between service-centred and needs-centred assessment; the former consisting of checking suitability for particular services and the latter involving an independent evaluation of need leading to a consideration of possible responses. This distinction was made clear by most respondents who saw it important not to assess clients simply with the aim of slotting them into available services.

Nurses involved in needs-based assessment were perceived to require: knowledge of range of assessment methods and measures that address health and social care (including multi-professional assessment packages), and skills in their application; skills in encouraging vulnerable people to participate, particularly those with enduring mental illness or who exhibit challenging behaviour; understanding of shared action planning so that the rehabilitation of clients with long-standing mental disorders is not impeded by inadequate liaison between hospital and community services.

Some mental health respondents remarked on the potential dangers of home assessment with clients who might be unpredictable. They highlighted the need for good information on the background of users at referral to minimise risk of violence to both assessors and users.

Cat 9 Case/care management and different levels of user support

Several learning disability respondents discussed the services needed to deliver varying levels of support to enable users to lead an ordinary life in community settings. They described examples from daily practice which are broadly in line with levels of support recently specified by Kay *et al* (1995):

- intermittent support - support provided as needed usually during crisis or transitional periods
- limited support - consistent support over a defined time period
- extensive support - high or low intensity but regular support which is not time limited and is delivered in one or more environments
- pervasive support - consistent, high intensity support provided across different environments.

Our learning disability respondents suggested that nurses and care staff with different levels of educational preparation are required to support users at these different levels, but a consensus over what programmes should be offered did not emerge.

Turning to mental health clients, several key informants pointed out that case/care management is transforming the nature of mental health nursing work and that this needs to be reflected in the organisation of pre- and post-registration nurse education programmes. Three levels of educational preparation were identified by several mental health respondents:

1. A small group of highly trained nurses to deliver services to a relatively small number of the most challenging cases in a catchment area and to act as supervisors within case/care management systems. Ideally these nurses will be educated to master's degree level in psychosocial and behavioural interventions relevant to this challenging group. Thus they will follow a Thorne type course programme but at a higher academic level. An example of this sort of course is the MSc in Mental Health Interventions offered by Middlesex University, which includes modules in case management as well as research methods and sets these within the context of contemporary developments in mental health care.

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2. Nurses with general case management skills able to support mental health users whose health is relatively stable but who may require supportive intervention with families (e.g. family therapy) and medication management. These nurses would be products of diploma programmes and undergraduate degree courses in which case management skills are addressed.
3. Community support workers or user case managers to support a large proportion of mental health service users whose health is reasonably stable, who have a job and/or live with their family. These people will be supervised by nurse case managers who will also provide periodic re-assessment and direct care if necessary.

An important point made by several respondents from both specialties was that case/care management models lack coherence unless nurses are proactive and resourceful to make the best use of the service infrastructure for the benefit of users. Case/care management also requires that nurses have a comprehensive knowledge of the range of services available on which to draw and how to put pressure on agencies to meet individual user's needs. Several respondents saw that, to embrace the role of case manager, nurses need to overcome their reluctance to move away from their traditional direct care role towards a more coordination role.

Valued were nurses who: have an adaptive, flexible and non-territorial approach to role development; are knowledgeable of case management, and networking and staff supervision essential for service management; are proactive initiators rather than reactive copers, thus they will network available services effectively and see possibilities beyond the standard services.

Readers will note that we do not distinguish between case and care management nor that care management is often located within a social services model and case management within a health model. Care and case management were used interchangeably by our respondents and key informants. In deciding what to do about this, we followed the recommendation of Bleach and Ryan (1995: 3-4, our italics). It is worth quoting them at length:

> '.... many different authorities (locally, nationally and internationally) had begun to differentiate for themselves between different forms of working by using the terms Case Management, Care Management, Care Co-ordination and Care Programming to mean different things. Often the differentiation was along the lines that Case Management was more "hands on" - actually providing one-to one work and support; Care Management was usually used to suggest a more remote, brokerage style of service; Care Co-ordination tended to be used to describe the Care/Case Management style of work undertaken by people who also had other parts to their job description; and Care Programming was used to denote the specific role within the Care Programme Approach responsibilities of the health service as set out in legislation. ..... *In reality, it is safest to assume that every*

> *individual, let alone every authority, will have their own different definition of what is meant by these terms.* Thus, it is safer to assume that what one person means by a term is the same as one's own understanding. Many hours of confusing and ultimately fruitless debate may ensue from such lack of clarity but, at the same time, much convergence of views and understanding can be achieved by exploiting the initial ambiguity.'

Cat 23 Genericism and specialism and the future of the mental health and learning disability specialties in nursing

This category contains the views of the future role of the learning disability and mental health nurse. An important theme that emerged from a large number of respondents was that nurses in both specialties are seeking a role distinct from, but collaborative with, other professions. Several respondents reminded us that the identity of mental health nursing in the past was linked closely with hospital care and with psychiatrists. In an attempt to free itself from what was perceived to be medical domination, mental health nursing has been developing its own ways of working; some beneficial, such as forging closer bonds and alliances with users, but others less so, such as the trend towards isolationism. A key informant cited as evidence of this isolationist trend the nursing models movement and mental health nursing textbooks of the 1970s which deliberately eschew psychiatric terminology in favour of an obscure American-English nursing jargon.

Samson (1995) has argued that medical dominance in British psychiatry may be fracturing as a result of the policy switch towards community mental health services and the managerial reorganisation of the health services. This view was shared by several respondents who reported that doctors have lost considerable influence to social workers and clinical psychologists. Some respondents felt that mental health nurses are also in danger of losing influence because of their medical links and they need to re-establish their identity. The emphasis of the review of mental health nursing (Department of Health 1994) on establishing a partnership with users was broadly supported, although several respondents remarked that the report is short on detail on how this can be achieved.

Learning disability respondents were rather more positive about the achievements of learning disability nursing which was perceived to have long ago broken its links with hospital care, although not always in the public mind. Of more concern to our respondents was the lukewarm attitude of other nursing specialisms towards learning disability nursing and the lip service given by some professional bodies to its unique identity. The long established post of Learning Disability Nursing Adviser to the RCN and, more recently, the commissioning of Kay *et al*'s (1995) report by the Chief Nursing Officer of England, which was in train when we carried out our data collection, were seen as positive moves towards protecting the future identity of learning disability nursing.

The view of most learning disability respondents was that nursing at present provides the best possible educational preparation for professional carers of learning disability clients. However, the view of mental health respondents was mixed. A key informant and some other respondents suggested combining mental health and learning disability nursing. The argument that supports this suggestion points out that the separation of mental health and learning disability nursing is an historical accident. Combining them again would reflect the organisation of psychiatry which covers the full range of psychiatric problems. Moreover, the interventions needed by these two client groups are broadly similar. Both need information, support and help with how to cope. The target of intervention with learning disability and mental health clients is the mind; mental health clients have limited reasoning and learning disability clients have limited understanding, so the argument goes. Thus the mind is the root of their problems. This is not so much the case for people with physical illness (even though it may have psychological effects) who are the proper province of general nurses.

A counter argument which was put forward by key informants points out that the combined model makes a false and simplistic distinction between mind and body. Also, in reality, the needs of the two user groups are very different; one group is ill, the other is not. Moreover, the objectives of care are not the same. With a fair proportion of mentally ill people at least recovery can be expected and with some conditions (e.g. affective disorders) a cure. By contrast, the objective for clients with learning disability is to lead as normal a life as possible in the community; recovery and care relate to disease and illness, and so are not appropriate. So there is a conceptual difference between the two groups although both do have specific educational needs that are rather different to patients with physical illness.

On a similar tack a key respondent with a mental health nursing background supported the idea of learning disability nursing being a post-registration qualification for mental health nurses. The argument presented is that with genetic screening there are essentially two kinds of learning disability client: those with brain damage who need physical nursing, rehabilitation nursing and mental health nursing; and those who need help to lead as independent a life as possible. This second group is the province of social workers although nurses may be helpful for people with profound and challenging behaviour problems.

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Learning disability respondents did not consider that their discipline is best linked with mental health nursing. For them the more important issue is its place in the family of nursing or allied to social work. Most respondents felt that learning disability nurse training has much to offer people with learning disability and is the most comprehensive education for people wanting to care for learning disability clients. They welcomed the report by Kay *et al* (1995) as clarifying and highlighting the contribution of the learning disability nurse to client care. Others were less certain. One key informant pointed out that it all depends upon the sort of role that the learning disability nurse will occupy in future services: the health-gain professional, the manager of residential services, or the combined health and social care worker. The first two of these roles would be best supported by learning disability remaining as part of nursing and the third within social work.

The health-gain professional role implies that nurses have special competencies which draw upon the origins of nursing as an adjunct to medicine. Learning disability nurses in this role might be attached to primary health care teams or work in other community settings, and act on a consultation basis as any other skilled clinical professional. They would deal with: ambulation, physical management (e.g. sleep, diet, incontinence and feeding problems), and physical development (e.g. detection of sensory deficits, setting goals and programmes for the management of challenging behaviour). All these health gain roles could be performed by a specially trained health visitor (for early years of a child's life) and thereafter by a community learning disability nurse. This role would be best supported by the retention of learning disability nursing and by re-establishing close links with the biomedical tradition of nursing care (as discussed in Cat 2).

The manager of residential services role is the traditional role of the learning disability nurse. It may be considered less satisfactory to some nurses than the health-gain model because it reflects a service that is divisive in that it separates clients who have additional problems (e.g. challenging behaviour, multiple handicaps) from those who do not. Separation of clients in this way rests on the fallacy that people with additional problems have more in common with each other than with other people. People with enduring problems are picked up by the NHS and nurses are involved; people with less severe problems fit into a social care model managed by social workers. The knowledge base for nurses would be biomedical care and residential care management.

If health and social care roles cannot feasibly be separated, this suggests that what is needed is one worker qualified for both components, with an understanding of behaviour and language development and knowledge of how to support people in a relationship. Whether this person is best prepared through the nursing or social work route continues

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as an open question. Some argued that policy-decisions need to be made about the new role before training implications are clear.

There was agreement that both nursing specialties need to establish themselves at the forefront of community based services, but there was disagreement as to how this might be achieved, in particular, whether pre-registration education should follow a specialist or generic route. This debate is relevant to nursing as a whole but is intensified in the context of the present study because genericism is perceived by many of our respondents as a threat to the minority branches and especially to those (arguably mental health and learning disability) which are not rooted in the biomedical tradition of general nursing. The debate was perceived by many respondents as central to the future of the two nursing specialties and we draw upon the strong views expressed to develop 'ideal type' models of future educational preparation in Chapter 7.

6.8 ENDNOTE

In this chapter we have drawn the findings into categories and themes which summarise the main issues facing mental health and learning disability nurses as described by our respondents. The next chapter draws on the material discussed here and in Chapter 5 to specify requirements for skilled practice and for nurse education and develops models of educational preparation which are likely to inform the future development of education in the two nursing specialties.

CHAPTER 7

CONCLUSIONS: REQUIREMENTS FOR SKILLED PRACTICE AND EDUCATION AND FUTURE DIRECTIONS

In this chapter we specify requirements for skilled practice and for education that emerged from the data and present these under the main themes identified in Chapter 6. We have not, though, attempted to identify a set of requirements that would be considered as comprehensive for mental health/learning disability nursing practice and education. Such an attempt is beyond the scope of this study. Rather, our aim is to highlight aspects of skilled practice and education which are emphasised by the demands for services for people with learning disabilities or mental health problems in the wake of the NHS & Community Care Act.

By requirements for skilled practice we refer to desirable attributes of nurses caring for clients and their families. We find that many of these requirements are similar in general terms for both mental health and learning disability nurses although the details will differ according to the particular user group involved and the location of care. In Section 7.1, for each theme, we summarise these requirements for both groups of nurses and follow this with additional requirements identified for each group separately. Also in Section 7.1 are the requirements for education; the implications for the organisation and conduct of nurse education in colleges and practice areas that can help nurses acquire the attributes of skilled practice identified. Although the requirements for education for learning disability and mental health nursing cannot always be distinguished separately, they can be interpreted differently according to specialty.

In Section 7.2 we develop Category 23 (Theme 7), *genericism and specialism and the future of the mental health and learning disability specialties in nursing*, to build models of nurse education which are likely to inform the future development of education in the two specialties. The models are grounded in the interview data from the respondents and key informants, and are informed also by our understanding of the education of mental health and learning disability nurses in England today.

7.1 REQUIREMENTS FOR SKILLED PRACTICE AND FOR EDUCATION

The requirements for skilled practice and for education for learning disability and mental health nurses are summarised in Boxes 7.1-7.7 under the seven themes which emerged from the data and are introduced in Chapter 6. The themes are not entirely independent and so there is some overlap between requirements across the themes.

7.1.1 Theme 1 Working with others

Requirements for skilled practice under this theme (Box 7.1) highlight the demands on nurses to create effective working within multi-professional teams and across service agencies and to explore ways of including users and carers as team members. Forming collaborative relationships which translate into an effective and seamless service was highly valued. This requires nurses to be confident that their knowledge and skills are grounded in education which identifies the evidence base of professional practice and also the national and local policy context of service provision.

Box 7.1 Requirements for skilled practice and for education: theme 1, working with others

Requirements for skilled practice

Highlighted by both MH and LD respondents

- Inter-professional and multidisciplinary teamworking skills including:
  - collaborative problem-solving skills
  - negotiation skills
  - assertiveness skills
  - fluent written and oral presentation skills
  - ability to draw on research based knowledge to support decision making
  - ability to work collaboratively with primary health care teams
- Confidence and knowledge to act as specialist advisers to:
  - non-specialists (i.e. general practitioners, health visitors and district nurses)
  - commissioning agencies on service planning issues as well as specific clinical issues (e.g. management of challenging behaviour, epilepsy, people with serious and enduring mental illness).
- Knowledge and skills required to undertake a community profile to:
  - determine local service activity
  - establish fruitful personal contacts
  - become aware of the extent of choice for users.
- Exploit ways of involving users and carers as members of multidisciplinary teams
- Multi-professional assessment and care planning skills
- Drawing upon understanding of the policy context of care including:
  - social and economic policy affecting the NHS
  - local health and social service guidelines and protocols
  - inter-agency referral mechanisms
- Networking skills
- Team building skills

Highlighted by MH respondents

- Creating effective multi-agency working across the statutory and voluntary services
- Specialist therapeutic skills which contribute to the 'skills bank' of the multi-professional team (e.g. cognitive behaviour therapy skills, psychodynamic counselling skills)
- Working relatively autonomously as case managers and key workers within a multi-professional team
- Knowledge and skills to effect discharge planning including:
  - collaboration with social services departments
  - understanding the roles of other workers and agencies in discharge and care
  - drawing on health and social needs assessment protocols
- Working with interpreters and specialist ethnic minority workers

Highlighted by LD respondents

- Taking a proactive role in co-ordinating multi-professional services
- Effective inter-agency liaison skills

Requirements for education

- Teaching methods that involve:
  - public performance and peer and lecturer feedback e.g. case presentations
  - opportunities to defend decisions and support hypotheses relevant to client assessment and care planning
  - carrying out a profile of a local community to identify available services
- Courses which provide:
  - a grounding in one specialist psychological therapeutic intervention in pre-registration programmes
  - ongoing debate about the proper roles of nurses within multi-professional services
  - shadowing other professionals in clinical placements to achieve an understanding of their roles, responsibilities and viewpoints
- Shared learning to:
  - foster good professional relationships
  - encourage ongoing debate about role boundaries
  - develop collaborative working
  - develop a common dialogue across professional groups
- Team training

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Knowledge and skills relevant to clinical practice need to be accompanied by skills in self-presentation, in marshalling arguments and presenting them coherently to people from different professional backgrounds. These skills are reflected in teaching methods which give students experience of public presentation and receiving peer and lecturer feedback. Case presentation, when all these elements are drawn upon for effective performance, was seen as particularly valuable as a learning exercise.

Shared learning with other professionals and shadowing them in clinical placements were seen as ways of fostering inter-professional relationships and giving nurses insight into the roles of other workers. Training in which the multi-professional team rather than the individual worker is the focus was also seen as valuable. One respondent remarked that individual courses are of limited value because there is often little scope for putting into practice what had been learned.

We have noted in Chapter 6 that views differed over the extent to which the boundaries of inter-professional work should be permeable. However, there was considerable support for nurses (particularly mental health nurses) specialising in a psychological therapy for clients and thereby contributing to the skills base of their multi-professional team. One suggestion was for pre-registration courses to give students a grounding in one psychological intervention that could provide credit towards a specialist qualification and be built upon in post-registration education. The intervention selected would help to give pre-registration courses in each college of nursing a distinctive character. There was concern that one DipHE course is much the same as another, although this was not the original intention.

7.1.2 Theme 2 Clinical practice

Requirements for skilled practice listed under this theme (Box 7.2) highlight the management and supervision roles of nurses in community based services and also their ability to see beyond the scope of existing clinical practice and initiate improvements. Nurses are expected to be knowledgeable about modes and methods of clinical supervision of individuals and small groups and to manage, supervise and assess the clinical work of junior students and support workers.

Box 7.2 Requirements for skilled practice and for education: theme 2 Clinical practice

Requirements for skilled practice

Highlighted by both MH and LD respondents:
- Developing professional practice including:
  - initiating and supporting user-centred service innovations
  - promoting continuity of care
  - seeking to improve clinical practice through research and development
- Managing professional practice including:
  - motivating staff
  - setting clear goals
  - fostering the development of research based practice
- Developing staff including:
  - individualised performance review
  - identifying training needs
  - clinical supervision skills
  - fostering reflective practice
- Personal management skills including
  - time management
  - stress management
  - workforce management
  - developing professional judgement
  - awareness of personal safety when home visiting
- Support of staff undertaking vocational (NVQ) qualifications including:
  - understanding support workers' responsibilities and work boundaries
  - caseload monitoring
  - assessment of NVQ level performance

No requirements for skilled practice were singled out for MH and LD nurses separately

Requirements for education

Highlighted were:
- Clinical placements for students that involve:
  - family based care
  - extended periods of client-student nurse allocation spanning residential and community settings
  - innovative user-centred services outside of the mainstream NHS and statutory social services departments
- Clinical supervision practices which:
  - promote awareness of personal safety when home visiting
  - enable students to assume a realistic level of responsibility for working with community based clients
  - role model supervision for use with clients and junior staff
  - provide students with opportunities testing out theory in practice and evaluating the results of their 'experiments' in discussion with peers and their college based lecturer.
- College based lecturers who:
  - work with service providers to develop and test clinical assessment strategies for students in both pre- and post-registration programmes which incorporate users' views
  - take on a limited caseload of clients and work under the supervision of experienced clinical staff
  - develop specialist consultation roles
  - develop their research skills under the supervision of those with an established track record
- Student recruitment policies which consider:
  - direct entry courses leading to single qualifications targeted these at support workers with clinical experience in the two specialties.
  - links between NVQ training and professional nursing education and direct recruitment into nursing from a suitable NVQ level.
- Continuing education programmes to enable clinical practitioners to keep up to date clinically and develop supervision skills.

Good clinical placements and supervision were seen as crucial to the education of students and many respondents advocated a shift in emphasis from the classroom to the clinical setting as a centre for learning. Suggestions included practical clinical experience with families to help them understand the scope of service provision and the challenges and pressures of family based care. Also increasing the range of clinical placements to incorporate more voluntary organisations which were seen to expose students to innovative and creative work practices that embody social approaches to care and give priority to users' views. Some respondents saw the rostered service requirement of DipHE courses as an impediment to increased use of the voluntary sector for placements.

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Another impediment was that colleges of nursing do not have a budget to fund student placements in services outside the NHS.

Many respondents wanted longer periods of clinical practice than are possible in many DipHE programmes. In particular client-student nurse allocation schemes over extended periods which span the hospital and community and allow students to follow the long and fluctuating health-illness careers of some clients and give ample scope for self-directed learning. Short clinical placements with clients who have serious and enduring mental health problems are of little value when their condition fluctuates over months and years. There was some support for reducing the length of the CFP in DipHE courses to one year and extending the Branch to two years to provide opportunities for longer placements with learning disability and mental health clients and enhance clinical skill development.

Community placements were criticised (particularly by mental health respondents) for not allowing students the opportunity to take responsibility and work relatively autonomously in a way that had been possible with ward placements. Clinical supervisors are concerned about personal safety and hesitant to allow students to practice clinical skills alone in clients' homes. Clinical supervision that encourages awareness of personal safety and is sufficiently flexible to allow students to assume a realistic level of responsibility was seen as an area that needs development. Trainee social workers were perceived to have opportunities to work relatively autonomously with users and are supported in this through tight formal supervision systems. Similar arrangements are not common for nursing students.

The emphasis on practice based learning for students was reflected in widespread support for lecturers taking on a small caseload and working under supervision for the equivalent of one day each week in a community mental health/learning disability care team. This might be managed on a sessional basis or through periods of secondment to practice settings. In a similar vein active continuing education programmes would enable clinical practitioners to keep up to date and develop supervision skills. Clinical practice was seen to be enhanced by research into practice, and college lecturers could take a lead in this if they were given opportunities to develop their research skills.

In Chapter 6 we pointed to the view that those support workers already based in clinical practice were ideal recruits for learning disability and mental health nursing but are put off by the stereotype they hold of general nursing. Direct entry courses leading to mental health or a learning disability nursing qualification were proposed as more attractive to experienced support workers than the usual DipHE route. Further consideration might also be given to linking NVQ training to professional nursing education and to direct recruitment into nursing from a suitable NVQ level.

7.1.3 Theme 3 Learning formats

In Box 7.3 we highlight aspects of curriculum content given priority as requirements for skilled practice listed under: aspects of general education that should be included in pre-registration courses; specific aspects of mental health and learning disability pre-registration courses; and aspects of curriculum content of post-registration programmes which are seen as particularly appropriate for shared learning across nursing branches and other health and social care disciplines.

The social sciences, particularly communication theory and practice and fostering good interpersonal relations, was highly valued by respondents who saw future nurses taking on a broad role incorporating aspects of health and social care. The biomedical sciences, notably psychopharmacology, psychiatry and general medicine were also valued, chiefly by those who saw the future role of nurses being firmly based in health (rather than social) care.

Requirements for education included criteria for lecturer recruitment, their teaching experience and opportunities for career advancement by developing clinical expertise, management skills, research experience and general scholarship. Joint appointments (education and service) were seen as a good thing as long as holders are well supported. The continuing debate over the merits of grounding students in the basic subject disciplines versus a more applied approach was identified as an issue for further discussion.

A variety of teaching and learning methods received support. Amongst these is information technology which was seen to have much untapped potential for teaching. The impression of many respondents was that this is exploited only by enthusiasts and that its potential benefits are yet to be reach students.

Shared learning received strong support. It was perceived as having many benefits for students and great potential for expansion if students on the same course can be assessed at different levels. We found little support for joint training leading to more than one professional qualification, but the merits of this should be kept under review.

Box 7.3 Requirements for skilled practice and education: theme 3 learning formats

Requirements for skilled practice

Curriculum content most frequently cited by respondents as valuable.

- General aspects of pre-registration courses
    - skills of critical analysis and basic scholarship (i.e. reading critically, writing fluently)
    - numeracy skills and basic statistics
    - anti-discriminatory practice (e.g. non-gender language)
    - skills for self-directed learning (including skills of reflective practice)
    - skills in self-presentation (public presentations, case presentations)
    - problem solving skills (aimed at adaptability to changing circumstances of care, becoming flexible thinkers and doers)
    - a liberal university education which allows nurses to appreciate the profession within its social and political context.

- Valued aspects of MH and LD pre-registration education
    - interpersonal communication and counselling skills
    - teaching and health education skills
    - how to be a resource to other professionals
    - knowledge necessary to help clients with activities of daily living
    - working with groups (clients and other health care workers)
    - positive attitudes towards users and principles of care (user choice and decision making, risk taking, legal rights and responsibilities)
    - skills and principles of case and care management (including flexible roles)
    - skills relevant to the needs of priority client groups (long term severely mentally ill people, LD clients with challenging behaviour)

- Highlighted for MH nursing
    - knowledge of basic anatomy and physiology with specific attention to neuro-pharmacology and basic neuro-psychiatry (not universally supported but a prominent view)

- Highlighted for LD nursing
    - practical skills of LD nursing (e.g. managing people with challenging behaviour or severe handicap)
    - attention to the emerging issues (i.e. abuse, spirituality, sexual expression, advocacy).

- Shared teaching in post-registration education, focused on:
    - client groups (e.g. adolescents, those with dementia, the seriously mentally ill)
    - therapeutic interventions (e.g. family therapy),
    - particular aspects of care and treatment (e.g. courses on child protection)
    - keyworking and case management (e.g. joint patient assessment between health and social services, including developing joint assessment forms, written material and the structural links between health and social services departments)
    - staff re-training for community care
    - financial budgeting
    - management and leadership skills
    - legal issues
    - principles and practice of research
    - counselling
    - stress management
    - crisis intervention.

Requirements for education

- Criteria for lecturer recruitment to include:
    - qualified and experienced nurses
    - being a graduate and preferably with a post-graduate degree
    - competent, confident and credible
    - a history of professional development since registration
    - interested in pursuing clinical practice and not simply teaching
    - interested in developing research skills
    - personal qualities (including enthusiasm and willing to give time to students)
- Lecturers to have a teaching qualification or a period of supervised practice and in-house training.
- Colleges to:
    - maximise opportunities for career development of lecturers through supporting opportunities for them to develop research, specialist clinical and/or managerial skills
    - continue to explore the potential of joint appointments (education and service) and how they might be supported in their role.
- A variety of teaching methods received support including:
    - learning interpersonal and communication skills through videoed role play and feedback
    - well planned and executed lectures involving opportunities for students, even in large groups, to ask questions;
    - student-led seminars attended by informed lecturers
    - branch specific seminars in support of key-lectures.
    - teaching opportunities offered by information technology.
- Curriculum planners to continue to:
    - debate the merits of grounding students in the basic subject disciplines versus a more applied approach.
    - explore opportunities for shared learning across multi-professional groups and differential levels of assessment.
    - debate the merits of joint training

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7.1.4 Theme 4 User enablement and empowerment

Requirements for skilled practice listed in Box 7.4 highlight the importance of nurses recognising user empowerment and advocacy as fundamental to the new relationship between user and nurse. These factors constitute the hallmark of community based care and are not optional extras to be tagged onto traditional services. Thus a key nursing responsibility is to establish a partnership with client and carers and explore practical ways in which users and their families can be involved in their own care and in planning and running services.

Box 7.4 Requirements for skilled practice and education: theme 4, user enablement and empowerment

Requirements for skilled practice

Highlighted by both MH and LD respondents:

- Recognising user empowerment and advocacy as fundamental to the new relationship between user and nurse
- Forming collaborative and empowering relationships with users
- Engaging clients and carers in their care in ways that are acceptable to them. Including:
  - facilitating user participation in assessing health and social care needs
  - incorporating user choice in planning and prioritising care
  - considering how far users need, and are given, help whilst respecting the right of users to make their own decisions.
- Exercising influence on the political process to improve services for clients
- Understanding the nurse's role in relation to advocacy, including:
  - working closely with advocacy services
  - recognise advocacy issues within the nurses' role
- Record-keeping skills including:
  - separating facts and values
  - maintaining confidential records
  - skills in multi-agency record keeping
  - skills in using interdisciplinary records
  - incorporating users' views
  - taking account of the Data Protection Act and other relevant legislation
- Using the case record to promote user participation
- Skilled in giving information to users and carers on
  - drugs
  - treatments
  - likely prognosis
  - statutory responsibilities
  - the complaints procedure
  - the range of services available locally
- Ensuring informed consent
- Welfare rights skills including practical assistance (letter writing form filling)

Highlighted by MH respondents:

- Ability to empathise accurately with users and thus appreciate their needs
- Skills in psychoeducational models of family work to promote awareness and collaboration
- Offering and facilitating user choice

Highlighted by LD respondents:

- Skills in forming collaborative and empowering relationships with those who exhibit challenging behaviour
- Sophisticated and wide ranging negotiation and communication skills to ensure participation
- Information technology and publishing skills to improve clarity of information for users
- Health promotion and health oriented care skills

Requirements for education

- Curriculum content relevant to the requirements for skilled practice including:
  - principles of care and values clarification
  - user empowerment strategies and skills
  - health promotion at the level of the individual and society
  - knowledge of client's problems, treatments and prognosis
- Involving clients and carers in:
  - curriculum planning and design
  - teaching
  - assessment of students
  - course evaluation and review

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Some clients may have unrealistic expectations. Others may seem to prefer to be 'objects' of treatment and care rather than active participants. Nurses have to consider how far users need, and are given, help whilst respecting the right of users to make their own decisions. Nurses must also learn to be persistent under adverse circumstances; learning the skills required to take an active approach at referral and at different points throughout the care process in an effort to engage clients in ways that were acceptable to them. Nurses who achieve this appreciate that users' scepticism and mistrust may arise from the nature of mental illness and disability as well as unsatisfactory experiences with services.

The case record was identified as a potentially valuable medium for involving users in their care as long as nurses have good record keeping skills and understand the need for sensitivity and tact when writing case notes to which users have access and to which they may contribute. Highlighted too was the nurse's role in ensuring that clients and carers are well informed on the many issues relating to their care (e.g. alternative treatments, potential side effects of any treatments, the nature and likely course of their illness, health education information). This requirement accords with recent policy (Department of Health 1991b) and professional literature (Department of Health 1994). It requires nurses to be confident in their knowledge and competent in its delivery.

Highlighted by mental health respondents was the ability for nurses to empathise with users, the use of psychoeducational models of family work to engage carers and the provision of choice. Learning disability respondents emphasised the challenges of forming empowering relationships with clients who exhibit challenging behaviour and the sophisticated communication skills involved.

Requirements for education include: relevant curriculum content; involving users and carers in student teaching and, perhaps more important, in curriculum planning and development, and assessment of students in ways that do not constitute tokenism; and health promotion strategies, including support for clients and carers to exercise their rights and demand improved health care services.

7.1.5 Theme 5 Responding to the market and service priorities

The requirements for skilled practice in Box 7.5 are concerned with maintaining a high quality service which is economically viable and responds to purchaser's requirements and clients' changing needs.

Box 7.5 **Requirements for skilled practice and education: theme 5, responding to the market and service priorities**

Requirements for skilled practice

Highlighted by both MH and LD respondents:

- Skills concerned with developing and sustaining services which are relevant and responsive to user need and purchasers' requirements, including:
  - advising purchasers on commissioning services which meet the needs of priority groups of users
  - respond to the demands of relevant legislation
  - contracting skills
  - marketing skills
  - resource management skills
  - budgeting
- Skills concerned with maintaining and improving service quality, including:
  - clinical audit skills for use across voluntary and statutory sectors
  - incorporating clients' and carers' views in service evaluation
  - skills in the critical analysis of research
  - implementing research based practice
- Providing culturally sensitive services
  - racism awareness
  - knowledge of anti-discriminatory legislation

Highlighted by MH respondents:

- Additional skills concerned with meeting the needs of people from ethnic minorities, including:
  - identification of unmet need
  - targeting services for minority ethnic groups
  - racism awareness of staff
  - providing ethno-sensitive services and care
- Evaluating the Care Programme Approach
- Skills relevant to the care of people with severe and enduring mental health problems:
  - working with users who do not comply with treatment (particularly medication)
  - cognitive behavioural treatment of positive symptoms
  - social skills training
  - early signs monitoring to prevent relapse
  - psychoeducational packages developed around the concept of expressed emotion
  - crisis intervention
  - flexible working to meet users' needs (e.g. out of hours services to meet leisure and social needs)
  - perseverance with clients under adverse circumstances
  - maintaining a partnership with the client over the long term
  - maintaining interest and commitment
  - consultation skills to support non-specialists staff working with those users not considered to be seriously mentally ill

Highlighted by LD respondents:

- Long-term care skills with those with multiple needs, including:
  - flexible working to meet users' needs (e.g. out of hours services to meet leisure and social needs)
  - perseverance with clients under adverse circumstances
  - maintaining a partnership with the client over the long term
  - maintaining interest and commitment
- Therapeutic skills including sensory stimulation techniques
- Generic medical skills for users with multiple needs, including:
  - pressure sore prevention
  - limb positioning
  - managing feeding difficulties
  - incontinence management
- Responding effectively to challenging behaviour by drawing on evidence based interventions including:
  - behaviour modification,
  - gentle-teaching

Requirements for education

- Curriculum content to include:
  - social and health policy to ensure students understand the workings of the health care market
  - current methods of care organisation (e.g. case/care management, key working) and the role of nurses within multi-professional services
  - policy and legislation relevant to the care and treatment of clients in priority groups
  - racism awareness and anti-discriminatory training
  - quality assurance and clinical audit
  - specialist therapeutic skills which contribute to the skills basis of multi-professional clinical teams
  - models of consultation and liaison psychiatry
- Measures to promote ethnosensitive care, including:
  - incorporating language electives in pre- and post-registration education
  - targeting nurse recruitment at those from ethnic minorities who are bi- or multi-lingual
- Colleges which:
  - respond quickly to the needs of purchasers and service priorities
  - draw upon the expertise of purchasers of services in teaching and drawing up curricula
  - reflect the demands of the market for skilled nurses by orientation of courses towards local and national priorities.
- A fail-safe mechanism for funding minority branch programmes which are vulnerable to the health care market.

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Requirements for education emphasise the need for nurses to understand the health care market, and the roles and functions of different agencies and personnel. Highlighted was the importance of appreciating the distinctive contribution of and funding base of the private and voluntary sectors. Nurses who have the expertise to advise purchasers of service demands and priorities, based upon their skills in community profiling, and who have a working knowledge of relevant legislation, are highly valued. The provisions of the NHS & Community Care Act (1991), the Mental Health Act (1983), and the requirement for supervised discharge (planned during the course of this study and now introduced by the Mental Health Act - Patients in the Community (1995) were most often mentioned.

Clinical audit is now part of professional practice and is increasingly incorporated into contracts between service providers and purchasers. Nurses have to understand the principles and practice of clinical audit, including how to incorporate users' views within service evaluation. Nurses who have a working knowledge of research methods, particularly those that might be used in quality assessment, are able to incorporate clinical audit into their practice without too much difficulty.

Respondents from both specialties gave priority to developing ethno-sensitive services for people from minority groups and underpinning these with training in race awareness and anti-discriminatory practice. Highlighted was the importance of understanding ethnic minority cultural influences as they affect daily life; this requires learning to be grounded in everyday life-styles of different cultures. Also understanding the cultural and ethnic similarities and differences within and between ethnic groups and the meaning of learning disability and mental illness within different cultures.

Mental health respondents put priority on the care of people with serious and enduring mental health problems and on interventions which aim to minimise the symptoms and distress experienced by this client group. Examples include cognitive behavioural treatment of positive symptoms (Kingdon *et al* 1994, Tarrier 1992), social skills training (Vaccaro & Roberts 1992), early signs monitoring to prevent relapse (Birchwood *et al* 1992), and psychoeducational packages developed around the concept of expressed emotion (Brooker *et al* 1993, 1994). Important too are skills in consultation to support non-specialist staff working with users not considered to be seriously mentally ill.

A priority for learning disability nurses was skilled long-term care of people with multiple needs and those who exhibit challenging behaviours. Important too (especially for learning disability nurses) was giving priority to meeting the leisure and social needs of users living at home (e.g. developing out-of-hours and weekend services, drop-in centres). Understanding the stress experienced by carers at home with responsibilities for severely disabled people was emphasised. Also skills in information giving and family liaison and psychosocial care (e.g. stress management, giving and arranging practical help).

Requirements for education include measures to promote ethno-sensitive care such as incorporating language electives in pre- and post-registration education and recruiting more nurses from ethnic minorities who are bi- or multi-lingual; so targeting black and Asian groups and challenging a stereotype, held perhaps most strongly by Asians, that nursing is a low status occupation.

Important too was lecturers who respond to demands of the market by drawing upon the expertise of purchasers of services and social and health policy experts in curriculum planning. The curriculum content has to reflect current methods of care organisation (e.g. case/care management, key working) and the roles of nurses within multi-professional services. Placements for students in care settings which adopt contrasting models to service delivery (e.g. clinical and brokerage case management models) was suggested as one way to promote a constructively critical appraisal of current methods of work organisation.

One suggestion mentioned previously under Theme 3 put forward to meet the demands of service providers for skilled personnel in multi-professional clinical teams is that pre-registration courses provide students with a grounding in at least one type of psychotherapeutic intervention. Which intervention is selected can depend on the requirements of local service providers, the skills of lecturers and the interests of students. It is important to orientate these courses towards local as well as national priorities, possibly through the medium of the 'specialist' placement which is a feature of many DipHE courses. People with serious and enduring mental health problems, those with multiple disabilities, those exhibiting challenging behaviour and clients from ethnic minorities have previously been mentioned as belonging to priority groups for service delivery and for specialist placements.

Two other groups are also important foci for specialist placements. The first is mentally disordered offenders in specialist and acute in-patient units. The Reed Committee (Department of Health 1992c) concluded that more nurses should be working in prisons and courts to divert offenders from jail and that nursing students should have a suitable practice placement in order to understand of the problems of mentally disordered offenders. There can be a knock-on effect in that other in-patient treatment facilities,

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such as acute in-patient psychiatric wards, will receive increasingly disturbed and potentially dangerous individuals who have been diverted from the courts (Atakan 1995).

The second group is mentally ill people who misuse substances. This has been identified as a growing problem in England (Smith & Hucker 1994) and these individuals present nurses with complex symptoms and associated problems such as violence and non-compliance with treatment. The recent ENB (1995) research project on nursing and substance misuse concludes that substance misuse education and training should be an integral part of all nursing curricula.

As mentioned in Chapter 6 concern was expressed about the vulnerability of minority branch programmes in the face of what was perceived to be an increasingly unregulated health care market. Several respondents saw the need for a fail-safe mechanism for funding minority branches, possibly through:

- additional funding for minority branches and specialist courses (i.e. parallel to funding by the regional health authorities). Some key informants thought that the Higher Education Funding Council (HEFC) might contribute by funding the universities to develop specialist direct-entry degree courses, outside the DipHE framework
- a mixed system of funding by the NHS and the HEFC. A key informant pointed to the advantages of this arrangement for medical education which is able to look to the regional health authority and the HEFC for funding. He suggested that funding for nursing may be best protected by emphasising its identity as a vocational discipline and by following medicine's example; that is to say, some nursing academics would be based in higher education but appointed on NHS contracts
- identifying and supporting regional centres for education. This is especially relevant to learning disability nursing where the numbers of students are small and have fallen to the point at which there is a danger that they will not be represented in DipHE courses.

7.1.6 Theme 6 Values

High quality mental health and learning disability nursing practice was seen by many to depend on nurses holding values which embody respect for clients and carers and seek to shift the balance of power towards clients and away from health and social care professionals. These issues are implicit within the requirements for education specified in Box 7.6.

Box 7.6 Requirements for skilled practice and for education: theme 6, values

Requirements for skilled practice

Highlighted by both MH and LD respondents:
- Value the perspectives of users and carers and their rights to good quality services. Considered important was:
  - a non- judgmental approach towards clients
  - commitment to continual improvement of services
  - respecting users wants as well as needs and seeking to meet them
  - appreciating that wants and needs are dynamic and thus require a commitment to continuous improvement of services
  - commitment to records that are open and accessible to users
- Respecting other professions and team members and willingness to work flexibly with them
- Toleration and open-mindedness to alternative lifestyles which do not threaten health
- Being committed to mitigating social factors which have a negative impact on mental health

Highlighted by MH respondents:
- Valuing the standards and expectations of users
- Being committed to user empowerment
- Ensuring confidentiality of user information within the health care team
- Being committed to the welfare of people with serious and enduring mental health needs
- Being committed to open and honest relationships with users and carers based on trust and respect

Highlighted by LD respondents:
- Being committed to implementing change indicated by service evaluation
- Skills in unpacking the ethical dilemmas facing community practitioners
- Being committed to maintaining people with multiple disabilities in community care settings

Requirements for education

- Values clarification focusing specifically on discriminatory practices
- Exploration of values underpinning care such as normalisation and social-role valorisation
- Ethical reasoning

Respondents saw it as essential that users' desires are seen to be as important as their needs with the result that constant innovation and change characterises a high quality service. It is important too that students develop toleration and open-mindedness to the ways in which people live and accept alternative lifestyles that do not constitute a threat to health. Skilled nurses also recognise and are committed to mitigating the impact of social factors on people's mental health and quality of life. The aspects of practice now incorporated under the heading of public health nursing (Standing Nursing & Midwifery Advisory Committee 1995) include: understanding population health needs; contributing to the commissioning of services; instigating collective and collaborative action; and focusing on health promotion at the level of the individual, the family and society.

Requirements for education include: values clarification incorporated within courses; exploration of values underpinning care such as normalisation and social-role valorisation and the ways these can be used to develop and evaluate services and nursing care practices; and exploration of ethical dimensions of practice.

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7.1.7 Theme 7 The impact of new models of care

Here we cover requirements for skilled practice contingent upon assessment of clients in the context of their families and communities and modes of community care work organisation, such as case and care management (see Box 7.7).

Box 7.7 **Requirements for skilled practice and for education: theme 7, impact of new models of care**

Requirements for skilled practice

Highlighted by both MH and LD respondents:
- A range of case management skills, including:
  - interviewing skills
  - skills in needs based user assessment using standardised measures
  - nursing assessment in the context of multidisciplinary assessment
  - user assessment incorporating user-led and self-assessment elements
  - critical appraisal of different methods of care organisation
  - understanding stages of the care process (i.e. consulting and involving the client; formulating problem statements; monitoring, reviewing and evaluating the individual care cycle)
  - knowledge of local services which are available and which might be included within care packages
  - engaging with clients to build a relationship of trust, listening to them, seeking to understand their perspective without introducing personal bias
  - knowledge of safety precautions, particularly on home visits, and predictors of aggression.
  - understanding the health implications of specific social issues (e.g. resettlement, cultural factors, housing, employment)
  - skills oriented towards the delivery of differing levels of support to clients using an adaptive, flexible and non-territorial approach to multi-professional teamwork.
  - able to realistically appraise their skills and to be proactive initiators rather than reactive copers.
  - able to see possibilities beyond the standard service

- Able to contribute to collaborative assessment with other workers using established protocols for multi-professional assessment. Specific skills considered crucial to the nurse's role in needs-based assessment included:
  - critical knowledge of range of assessment methods and measures that address health and social care, and skills in their application
  - adapting assessment to individual need and learning how to encourage vulnerable people to participate
  - skill in undertaking assessment with the client and shared action planning with hospital and community providers
  - understanding how to work with other occupational groups to develop multi-professional assessment packages
  - interpersonal communication (e.g. listening skills, creating an informal atmosphere at interview)
  - helping users to express their feelings and participate as much as possible in the assessment process
  - comprehensive and systematic risk assessment
  - understanding strategies for identifying unmet need in the community

Highlighted by MH respondents:
- Risk assessment and management (including de-escalation techniques for violence and aggression, break-away techniques)
- Assessment of:
  - dependency
  - prodromal symptoms indicating relapse
  - self-harm
- Prioritising caseloads

Highlighted by MH respondents:
- Assessing challenging behaviour
- Skills of service brokerage
- Clinical case management in the context of legislation and statutory responsibilities

Requirements for education

- Curriculum content which emphasises:
  - clinical assessment at the level of the individual, the family and the community.
  - clinical knowledge and a programme of clinical experience and supervision which generates realistic self-assessment and self-confidence and initiative.
- Exposure of students working in clinical settings to a variety of service delivery models
- The developing role of the nurse consequent upon changing modes of service organisation

Respondents noted that nurses need to contribute to the development of local strategies that identify unmet need in the community, conduct needs-based assessments using standardised measures, and contribute to collaborative assessment with other workers

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using established protocols for multi-professional assessment. Also important is the ability to undertake comprehensive and systematic risk assessment to include risk of self-harm, suicide and neglect, and risk of danger to others. Thus we endorse recent guidance from the Department of Health (1992c, 1993b).

A variety of assessment skills were mentioned and nurses were also seen to need knowledge of available local services which might be included within care packages; this was mentioned particularly with respect to successful discharge planning. Good interpersonal communication skills were seen as a prerequisite to skilled client assessment which included helping clients express their feelings and participate as much as possible in the assessment process.

Case management was seen to require nurses who adopt an adaptive, flexible and non-territorial approach to multi-professional teamwork. Such nurses are able to appraise their own skills, be proactive initiators rather than reactive copers and see possibilities beyond the standard service. Important too is understanding the health implications of specific social issues and skills that can deliver different levels of support. The levels required for people with learning disabilities, and could be extended to clients with mental illness requiring support within families, have been described as intermittent, limited, extensive and pervasive (Kay *et al* 1995).

Requirements for education included curriculum content which emphasises: clinical assessment at the level of the individual, the family and the community; sound clinical knowledge and a programme of clinical experience; and supervision which generates realistic self-assessment, self-confidence and the courage to take the initiative.

7.2 'IDEAL' MODELS OF EDUCATIONAL PREPARATION

We took as a starting point for this study the context of service delivery so as to identify the educational needs of nurses who work within and are able to transform these services in the future. We have been struck forcibly not by differences in opinion about the characteristics of these nurses and their educational needs but by the fact that these differences are so few. There seems to be a broad consensus on the requirements for skilled practice in mental health and learning disability nursing and considerable agreement on issues relevant to educational provision. It is encouraging for the future that a clear agenda for action has emerged and we hope that the requirements specified in Section 7.1 will provide a useful summary of this agenda for those charged with developing nursing curricula and running educational institutions.

Consensus about educational provision is by no means universal, however. Beneath the agreement on the outcomes and processes of mental health and learning disability nursing education that we have documented, we were struck by divergent views about the nature of mental health and learning disability nursing as practice disciplines and the implications of these views for the future shape of pre-registration educational preparation. We note in particular the debate between those who advocate what is referred to as specialist educational preparation and others who favour generic preparation. This debate is relevant to nursing as a whole but is magnified in the context of this study because genericism was perceived by many of our respondents as a threat to the minority branches and especially to those (arguably mental health and learning disability) which are not rooted in the biomedical tradition of general nursing.

In this section we focus on this debate as it impinges on mental health and learning disability nursing and we endeavour to represent the central ideas in 'models' of nurse education. The models are expressed as ideals. As such they represent reality, but do not reflect it. We present them as caricatures of extreme views so that their distinguishing features are clear. Thus the models are heuristics designed to bring together diverse ideas and to stimulate debate.

Two models are clearly independent: the 'specialist' and the 'generic' models. Another three models are partial in that they draw upon the first two: the 'pragmatic' model, the 'unity-of-nursing' model, and the 'social care' model. A common feature of the pragmatic and unity-of-nursing models is that they support the existing DipHE programme which is now the dominant form of pre-registration nurse preparation in the UK. The social care model is applicable principally to learning disability nursing.

We examine each model, taking into account the following points to bring out their characteristics:

- the desirable structure of pre-registration nurse education and academic progression in mental health and learning disability nursing
- the basis of nurses' knowledge and emphasis of the pre-registration curriculum
- the perceived expectations of service users
- attitudes to shared learning and joint training
- perceived advantages and disadvantages.

7.2.1 Model 1: The specialist model

The essence of the specialist model is direct entry to single qualification pre-registration courses in mental health or learning disability nursing.

The desirable structure of pre-registration training and academic progression

Specialists mourn the passing of dedicated specialist courses, leading to registration in mental health or learning disability nursing, that occurred as a result of the DipHE reforms. Most specialists advocate their revival but as courses based in higher education linked to academic qualifications. Most also support pre-registration courses at diploma level and resist a wholesale move to an all graduate profession. To take this step would, they argue, effectively exclude many people who have the potential to form helpful relationships with people who are mentally ill or have a learning disability from the profession simply on academic grounds. In any case, abandoning second level training would simply mean that trusts will recruit more vocationally trained care assistants and that opportunities for direct personal contact and the development of therapeutic relationships between qualified nurses and patients will decrease.

Opportunities for post-registration education should enable diplomate mental health/learning disability nurses to build upon an academic qualification while progressing in their professional careers. Courses are available, but many specialists emphasise the importance of building on therapeutic skills particularly those in the humanistic psychology tradition (e.g. counselling and psychotherapy courses).

The basis of nurses' knowledge and emphasis of the pre-registration curriculum

The reason for specialist preparation is the distinction between mental health and learning disability nursing knowledge and skills on the one hand from those of general nursing on the other. The specialist mental health nurse builds a therapeutic relationship between nurse and user as a vehicle for planning interventions in partnership with users and carers. Delivery of care is directed at helping users cope with the problems in living associated with their illness and make progress towards mental health.

This direct personal relationship is crucial to mental health nursing. It is a constant in the user's life and the heart of mental health nursing under all systems of service delivery (e.g. case/care management, team nursing, primary nursing). For some mental health specialists the exercise of the nurse's therapeutic relationship is most vividly expressed in their capacity to stick with and maintain relationships with long-term seriously ill people who experience recurrent health crises and periodically exhibit disturbed and aggressive behaviour. Nurses' capacity to diffuse and deal with aggressive situations is another hallmark of high quality mental health nursing which, by virtue of their training and much face to face contact with users, they do better than other mental health care professionals.

Specialists recognise the importance of having a grasp of biomedical aspects relevant to mental health care. However, the emphasis for most is primarily on the social science base of nursing practice, in particular communication theory and developing interpersonal therapeutic skills that draw particularly upon humanistic psychology, counselling and psychodynamic psychotherapy. Popular teaching methods include role play and other forms of experiential learning and an emphasis on supervision in clinical practice.

The emphasis for learning disability nurses is similar. They also build a therapeutic relationship with users but with the primary aim of promoting self-help within the community. The aim is to help people who have a learning disability to be ordinary people living ordinary lives (the normalisation principle). Like mental health nurses, learning disability nurse specialists are skilled at maintaining long-term relationships with profoundly handicapped people who may exhibit disturbed and aggressive behaviour. Learning disability nurses know their users so well, because of their prolonged and continuous contact, that they are the professionals most able to communicate with, understand and manage people with challenging behaviours.

Specialist learning disability nurses also emphasise the relationship between nurse and client as a vehicle for maintaining and improving the health of the user by mitigating the effects of disability, involving the user in community life, increasing personal competence and control, maximising choice and helping the family and others to support the user (Kay *et al* 1995).

The expectations of service users

Users value their personal relationships with mental health and learning disability nurses and first and foremost they want nurses who have the personal qualities and skills to forge such relationships. Mental health and learning disability nursing education should therefore draw primarily on the social sciences and interpersonal psychology rather than be based in the largely biomedical tradition of general nursing. Specialists argue that if qualified nurses withdraw from their direct care role users will increasingly distance themselves from biomedically based services; parts of North America were cited where this has already occurred.

Shared learning and joint training

Joint training with other health and social care professions leading to dual qualifications is rejected by specialists because it clouds the distinctiveness of the nurse's role and fudges the issue of what different occupational groups do and should be doing. Moreover, there would have to be good reason for having two occupational groups with overlapping roles when there could be one. But some shared learning is advocated and there are many possibilities for this particularly in post-registration education. Shared learning in pre-registration education, particularly with social workers, is also favoured because the basis of the curriculum in building, fostering and using inter-personal relationships for both professions is similar. Some shared learning with general nurses is also possible as long as the distinctiveness of mental health and learning disability nursing is recognised.

Learning disability nurses point to strategies for shared training between nurses and social workers in the 1970s as evidence of the pioneering spirit of the specialty. However, some specialists argue that this work had limited impact because it did not fit the plans for general nursing. This dominant force is seen to exercise undue influence on the direction of the minority branches of DipHE courses. Shared learning is once again on the agenda and learning disability nursing, together with social work, is perceived by specialists to be at the forefront of developments (Elliott-Cannon & Harbinson 1995). Merging mental health with learning disability nursing has been proposed but so far has received little supported from either specialty.

Advantages of specialist education and critique of genericism

Children at school often gain experience of caring for people with learning disability and mental health problems as a component of general or community studies courses and the fact that many find this an attractive job is confirmed by the number of able and energetic people working as unqualified social workers in voluntary organisations and statutory services throughout the country. These people are committed to a psychosocial approach to care and might go so far as to reject any profession associated with the 'medical model'. They are more likely to be attracted to social work, through the NVQ or diploma route, than to nursing. General and mental health/learning disability nurses are different breeds. Unqualified people currently working in learning disability and mental health services are not interested in general nursing; the stereotype of general nursing which is grounded in the medical model, does not appeal to them. They may, though, be attracted to mental health or learning disability nursing but, as long as general nursing experience remains a major part of pre-registration nursing education as in DipHE courses, these potential entrants will be lost to the profession. Specialist dedicated courses are much more likely to recruit this highly desirable group.

The current DipHE programmes dilute mental health and learning disability nursing expertise. This is inevitable in a generic programme. General nurses, through sheer weight of numbers and a stronger foothold in higher education, inevitably sway the curriculum towards the biomedical tradition and emphasise aspects of that tradition which are seen as most relevant to nursing general patients. A generic preparation (Model 2) will simply exacerbate this problem and is a luxury that mental health and learning disability nursing cannot afford. Mental health and learning disability nursing are psychosocial activities and much biomedical knowledge gained is redundant in practice.

A generic preparation of three years followed by a further period of specialist practice (Model 2) is detrimental to service users because nurses will inevitably be steeped in and unable to throw off the biomedical tradition of general nursing. Moreover, the cost of increasing the length of pre-registration nurse education will simply price nurses out of the health care market without any benefits to service quality.

7.2.2 Model 2: The generic model

Generic education can take a number of forms. One distinction considers whether generic education extends across a range of health and social care groups, or is confined to nursing. Generic courses could promote inter-professional educational preparation which creates new professional hybrids of existing occupations. A weaker version of this would be joint courses leading to dual qualifications, for example registration on the learning disability part of the UKCC register and the diploma in social work.

Generic education within nursing can lead to dual nursing qualifications (entry on more than one part of the register) or a single Registered Nurse (RN) first level qualification for all nurses. It is this latter vision of generic education to which the term is most usually applied.

The desirable structure of pre-registration training and academic progression

In retrospect DipHE courses established under Project 2000 are an unsatisfactory half-way house. DipHE was a move towards generic preparation which was compromised by fear of the expense and repercussions of losing the student labour force to the labour market. Genericists argue that nurse education should have had the courage not to compromise and instead to go for a generic three-year preparation for all nurses, based in higher education and leading to the RN qualification, perhaps modelled on some programmes in North America.

Many genericists favour three-year programmes leading to a first degree in nursing. Indeed, implicit within some notions of genericism is the assumption of an all graduate nursing profession. Other genericists would accept three-year courses leading to a diploma or a first degree depending upon the portal of entry. Following this students could choose to do a specialist year, or possibly more, in their chosen specialty. They would be clinically based, probably working as a basic grade staff nurse for the first year of specialised practice and would progress thereafter.

Post-graduate qualifications would comprise a portfolio of options at different academic levels that would suit people specialising in mental health/learning disability care. These post-graduate courses would be pursued through a combination of practice and study.

The basis of nurses' knowledge and emphasis of the pre-registration curriculum

The therapeutic relationship, as espoused by specialists, is not a reality in most services. Economic pressures mean that there is a constant push to look for more cost effective ways of delivering direct care. Thus it is simply not feasible for nurses to protect their direct care role.

Creating good care environments in a range of client care settings and, increasingly, supervising vocationally trained assistants, is now a primary role for mental health and learning disability nurses. Nurses are best placed to do this because they have a foot in the biomedical tradition and also in the social sciences, both of which would feature strongly in a well planned generic education programme. An all graduate nursing profession grounded in an initial generic preparation, in which nurses are freed from the role conflict and drudgery of service commitment, will increase the status of nurses within multi-professional health care teams. This will enhance their professional confidence and enable them to make a more robust contribution to the creation of care environments than hitherto.

There is much overlap between the skills and knowledge of all nurses. Nursing comprises the application of common skills across a range of human need and over a 24-hour, 7 days a week period. The emphasis of the pre-registration curriculum differs to that of the specialists. For genericists the key to the future is flexibility and the attempt of specialists to protect traditional direct care nursing roles is part of a professional protectionist agenda. If nursing is to flourish within cost-effective services it must adapt to a variety of service delivery patterns. Nurses must have the confidence and ability to leave behind their direct care role with patients and take on a wider brief. Skills of management and leadership are highly valued as the key to nurses managing and developing services to meet users' needs. These skills are linked to new forms of service delivery, such as case/care management.

The close relationship between mental health/learning disability nursing and general nursing locates all of nursing primarily in the biomedical tradition. Genericists see this as completely appropriate to the new care arrangements for mental health and learning disability users. These nurses recognise themselves as grounded in health and health care and this requires much closer allegiance to the biomedical model than has been the case for many years. Let social models be the province of social workers.

The expectations of service users

Users value their personal relationships with nurses but those with health care assistants can be just as beneficial if these people are properly supervised as part of an integrated health care service. Moreover, not all mental health and learning disability users need close relationships with nurses. What is important is careful assessment of the level of support individuals require and providing a planned package of care to address that need.

Specialist preparation of mental health nurses over 30 years has yielded few positive benefits for users. The growth of the user movement has highlighted deficiencies in mental health nurses' knowledge and skills; the limited interest and knowledge of some nurses about long-term medication management of seriously mentally ill people and inadequate knowledge of the physical illnesses experienced by users being two examples. Many of these deficiencies result from mental health nurses' neglect of the biomedical origins of the profession, their tendency to work independently from other members of the health care team and their relatively low status vis-à-vis other health care professionals. A move to generic education can improve the conditions under which nurses currently work.

Learning disability requires a wide repertoire of knowledge and skills to meet the multiple health needs of users and their families. Generic nurses are particularly valued for their work with users who have dual diagnoses or profound disabilities because of their unique combination of general, mental health and learning disability nursing training.

Shared learning and joint training

Joint training between all nurses at pre-registration level is favoured. Some genericists see this as just the beginning of a transformation of health care disciplines by extending joint training across professional groups and creating new varieties of health care worker. Others are just as cautious as specialists are of joint training with other disciplines and on similar grounds; it clouds the distinctiveness of nursing and fudges the issue of what different occupational groups do and should be doing.

Shared learning is favoured by genericists and there are many possibilities for this, in particular on issues raised by service delivery systems on which all workers need information and need to reach agreement (e.g. record keeping, confidentiality, advocacy, principles and procedures of referral).

Advantages of generic preparation and critique of the specialist model

In many ways DipHE courses represent the worst of all possible options for mental health and learning disability nursing. The dominance of general nursing throughout the curriculum, particularly in the CFP, means that, in effect, generic nurse preparation has arrived already by the back door. The result is a badly thought through pre-registration education for mental health/learning disability nurses. Moving purposefully to a generic three-year pre-registration programme, so expanding the existing CFP to three years, gives the minority branches much more opportunity to be clearly and fully represented.

Specialists go on about the importance of the therapeutic relationship, but it is not a reality in most services. The results of pre-registration nurse education leading to a single mental health/learning disability qualification has yielded few positive benefits for users. In seeking to distance themselves from general nursing, specialist mental health and learning disability nurses have neglected the biomedical tradition to the extent that they have increasingly distanced themselves from doctors and have not exercised the influence that they should on developing progressive health care services.

Specialists are swimming against the tide of unfolding events. Pressures for cost containment and the influence of nursing within Europe mean that the generic nurse is inevitable. The important thing is to seize the moment and make generic preparation as good as it can possibly be for nurses who elect to follow the minority specialisms.

Nursing, particularly mental health or learning disability specialisms, holds little appeal for well qualified people who are able to make a difference to the shape and quality of service provision. The trend in cost-efficient services is towards fewer knowledgeable and skilled nurses and more support workers. This trend offers great potential and attractions for nurses who are flexible and proactive. It implies the need for generic preparation that offers diplomas and degrees. People who cannot cope with, or do not want, a diploma or degree level education can enter through the vocational qualifications route.

7.3 VARIATIONS ON THE SPECIALIST AND GENERIC MODELS

We move now to outline three variants on the two main models.

7.3.1 The pragmatic model

As with the specialists the pragmatists mourn the passing of specialist pre-registration courses leading to mental health or learning disability qualifications but agree with the genericists that the trend is towards the generic nurse. In this situation DipHE courses represent the best chance that mental health and learning disability nurses have of retaining their unique identity and specialist skills. What is important is to rein in the dominant influence of general nursing in the curricula of diploma courses so that the specialist branches can flourish. Unless this occurs nurses who select pre-registration mental health and learning disability branches are not given sufficient opportunity to develop the specialist skills valued by service managers. This state of affairs is self-defeating because it plays into the hands of nurses - mainly general nurses - who doubt the existence of specialist skills in mental health and learning disability nursing. Rather, they see these skills as simple variants on those used by all nurses in their psychosocial care of patients (see unity-of-nursing model).

Pragmatists put emphasis on shoring up the boundaries of mental health and learning disability nursing within the curriculum. Attempts to define and re-define the role of specialist nurses to reflect the nature of changing services (for example, *Working in Partnership*, Department of Health 1994 and *Continuing the Commitment*, Kay *et al* 1995) are welcomed. For pragmatists the therapeutic relationship between nurse and user is important but it is no longer an adequate description of the role and skills of the mental health and learning disability nurse under the new service arrangements. Thus for example, case/care management as a form of service delivery and the orientation of services towards long-term mentally ill people, people with dual diagnoses and those with multiple disabilities, have a major influence on mental health and learning disability skills, and educational courses must adapt to meet them.

The structure and content of existing DipHE courses is crucial to pragmatists. They pay attention to the minutiae of curriculum planning, for example to the number of hours devoted to mental health and learning disability nursing in the CFP, to the specialist

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nursing qualifications and experience of mental health and learning disability lecturers, and also to the appointment of senior staff in colleges of nursing in higher education who have a background in and sympathy for the specialties.

7.3.2 The unity-of-nursing model

In common with the pragmatists, the unity-of-nursing model supports the current DipHE programmes but for rather different reasons. The unity-of-nursing model draws from the generic model in the belief that there is nothing distinctive about the skills of mental health or learning disability nurses compared to general nursing which also addresses psychosocial needs of patients. Shared learning is proposed across pre-registration branch programmes particularly for 'interpersonal skills' which emphasise therapeutic communication and humanistic counselling. Lecturers of these subjects are drawn from any nursing specialty, as long as they have an interest in psychosocial care and are skilled communicators. The specialist branch programme gives students the opportunity to practice these interpersonal and relationship skills in their chosen field. A key informant referred to these ideas as being part of a 'creeping colonisation' of mental health and learning disability nursing by general nursing. This colonisation has occurred, she said, over the last 15 years as general nursing has embraced psychosocial care so broadening its biomedical origins.

Popular mainly with general nurses, particularly those with a keen interest in psychosocial care, the unity-of-nursing model is criticised by specialists and pragmatists for simplifying the concept of nurse-patient (user) interpersonal communication. These critics argue that, for example, relating to a hallucinating and deluded person with a history of aggression requires a very different repertoire of interpersonal skills than those required to reassure an anxious person waiting for an operation. Proponents of the unity-of-nursing model are also criticised for holding to the concept of mental health nursing as being centred upon humanistic psychology and learning disability nursing as being exclusively social care. Also in failing to take account of the influence of changing systems of service delivery on the role of both nursing specialties.

7.3.3 The social care model

The social care model draws upon genericism and is relevant primarily to learning disability nursing. Reflecting the debate begun by the Briggs Report (Report of the Committee on Nursing 1972) and the Jay Report (Report of the Committee of Enquiry into Mental Handicap Nursing and Care 1979) about the nature of learning disability care, the social care model supports the move to base pre-registration learning disability nursing training in social work rather than in nursing on the grounds that learning disability nursing is a social (and therefore social work) rather than a health (and therefore nursing) specialty. This distinction is simplistic but the debate is complex yet fundamental to the future educational preparation of learning disability nurses.

Many learning disability users never see a learning disability nurse or, if they do, they cannot distinguish them from workers with a background in social work. Case/care manager and residential manager posts do not usually require someone with a nursing qualification. Nurses often take these posts but they do not necessarily regard themselves as nurses first and foremost. They and users and their families see them as knowledgeable professionals who have the requisite repertoire of social and health care skills.

A recent development in the debate was the Consensus Conference on learning disability nursing commissioned by the Chief Nursing Officer for England. The statement put out by the conference recommended that the pre-registration education and training programme in learning disability nursing should be replaced by training at post-registration level and that there should be greater attention to learning disability as a specialty within the CFP of DipHE courses.

As discussed in Chapter 3, the response by the nursing profession to the consensus statement was extremely critical (Brown 1994). Support for continuing a pre-registration learning disability branch programme within 'the family of nursing' was overwhelming. Respondents support shared learning and interdisciplinary work but insist that learning disability nursing skills exist and could be applied to the care of disabled people more generally.

The Chief Nursing Officer added her signature to these views in a letter in April 1994 which confirmed the future of learning disability nursing. She commissioned a study of the role of the learning disability nurse (Kay *et al* 1995) and workforce planners and education commissioners have been made responsible to the NHS Executive for promoting and monitoring the development of the specialty.

The tide seems to have turned, at least for the moment, against the social care model. But the debate will continue and our respondents expressed a range of views about the future of learning disability nursing. Proponents of the social care model support either joint training with social workers leading to dual qualifications, or merging the learning disability nursing specialty into a generic social work education with specialist components. In contrast, advocates of learning disability within nursing identify with either the specialist or the generic models. They argue that nursing currently provides the most comprehensive education for learning disability professionals because its grounding in the social sciences and the biomedical tradition gives it the edge in providing holistic care.

7.4 REFLECTIONS

We have been struck during the course of our enquiry by several concerns about mental health and learning disability nursing which were widely held by our respondents and the onus placed on education to bring about improvements. Four issues seem particularly important.

First, the perception is widespread that education of mental health and learning disability nurses is lagging behind developments in service provision and is not responding fast enough to service demands. This perception reflects a quickening pace of change in community based services compared to hospital based care in which practice and associated knowledge and skills are perceived as having a longer shelf life. Whereas education was once seen to lead and promote service developments, it is now seen to be failing to keep pace. This is partly attributed to nurse lecturers being out of touch with practice.

Second, the current low status of, in particular, mental health nursing and loss of confidence in the profession by the public. The low status of the profession is acknowledged in *Working in Partnership* (Department of Health 1994) and many of our respondents felt that the profession needs to make up lost ground to regain public credibility. Loss of credibility is partly a result of the many enquiries into abuse e.g. the Ashworth enquiry (Report of the Committee of Enquiry into complaints about Ashworth Hospital 1992) which give the impression of a badly trained workforce, the high profile cases of Ben Silcock, Christopher Clunis and others which brought tragedy to several families, and also a growing critique by service users who expose the limitations of professionals in responding to their need.

Third, concerns about what are perceived to be varying standards of nurse education in institutions of higher education across the UK. Our respondents noted the many different institutional arrangements between the universities and the former schools of nursing and are concerned about varying standards of teaching and academic attainment and the different levels of integration which have been achieved. The move into higher education

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is perceived to have gone most smoothly in the universities in which nursing departments were already established. However, even with these there is concern that the amalgamated schools of nursing, now known as institutes, are hermetically sealed units often situated in buildings away from the main campus; integration has not occurred.

Concern is also expressed about nurse lecturers who have been catapulted into higher education, often into very senior posts, without sufficient opportunity for professional development. These lecturers are overwhelmed by new and competing demands that include college and clinical responsibilities, keeping up to date clinically, and the pressure to do research. The working environment they find themselves in is very different to that of former schools of nursing.

Fourth, concerns about the structure of the diploma in higher education courses (established under the Project 2000 reforms in 1989) and the opportunities these programmes present for students from the minority branch programmes. Problems identified by our respondents are diverse. Enabling students to achieve sufficient depth of study in the CFP when lecturers have to expose them to all four specialties is considered by many to be impossible. Students in some programmes perceive the course to be in two sections, the 'academic' part (the CFP) followed by the 'practical' part (the branch programme), causing a division that runs counter to the notion of integrated theory and practice originally envisaged. Also, the broader problem of erratic academic progression. In some programmes, for example, students are expected to achieve 'level two' work within six months of starting the course, rather than in year three as originally envisaged by DipHE policy strategists.

These problems are not universal but were reported by a sufficient number of respondents to indicate that teething problems with DipHE courses remain. Recent research also confirms our respondents' concerns about these courses (Elkan & Robinson 1995). It would be wise to reserve judgement on the success of the DipHE initiative until more evidence comes available, not just that based on the first few cohorts.

Many changes are already in train, spurred on by recent reports such as *Working in Partnership* (Department of Health 1994) and *Continuing the Commitment* (Kay *et al* 1995), which we expect to address these concerns. In summarising widely held requirements for skilled practice and education and, by clarifying the assumptions underpinning the debate between specialists and genericists and the varying positions in between, we hope that this project will contribute to the process of change.

From the outset DipHE courses were intended to differ one from another to reflect local demands, but our professional experience suggests that they had had a uniformity which is only now starting to change. In the short to medium term we expect these courses to remain the dominant mode of pre-registration education in England. We expect each to mature into a unique programme and to respond to the needs of educational purchasers and users of the relatively new community based mental health and learning disability nursing services.

The arrangements for post-registration education are already diverse and our findings support this. Post-Registration Education and Practice (PREP) was perceived by most of our respondents as a positive step towards giving post-registration education greater priority, although the minimum requirement of five days each year is regarded as inadequate. Our findings also support development of high-level post-graduate qualifications which reflect a practice orientation, such as doctor of nursing (already offered by some universities, e.g. the University of Ulster) as an alternative to the conventional research weighted PhD. One of the biggest challenges for post-registration education in mental health and learning disability nursing, and in nursing more generally, which was highlighted in our interviews with clinical staff, is to change the way that post-registration education it is perceived by clinical nurses. They see continuing education and its funding as not their responsibility but that of their employer. There is a danger that, if nurses do not take responsibility for their own continuing education, it will be a service-led, competence based training with few research based academic links.

The signs are that nurse education is securely based in higher education and the debate is now at the margins; whether nursing departments should be in medical schools or multi-faculty health studies institutions and so on. In the medium-term we would expect the position of the new nursing departments within higher education institutions to strengthen as lecturers find their feet and rise to meet the challenges of their new posts.

The longer-term future of mental health and learning disability nursing education is more difficult to predict. The models of nursing education held by our respondents, and developed in this project to draw out their essential elements, are diverse and there is therefore little agreement as to the way forward in the long run. For some of our respondents the strong allegiance of mental health and learning disability nurses to one or other of these models, or more likely a combination of several, presents a disunited front which prevents the specialties from fashioning a coherent educational structure, particularly at pre-registration level. But, in fact, quite the reverse might be true. These diverse models can be seen as giving strength to mental health and learning disability nursing if they are reflected in a diverse education programme in which courses are fashioned to meet the changing needs and requirements of specific educational purchasers and service users. The consortia of service providers and purchasers may be a mechanism for promoting diverse educational arrangements and our prediction is that a greater variety of courses will begin to emerge. What is important is that the requirements for skilled practice and nurse education identified in this study should shape the curricula of courses irrespective of their underlying model. Providers of learning disability and mental health nurse education have to face the challenge of producing nurses who are able to meet the demands of service providers and purchasers working to tight budgets on the one hand, and maintain the standards of scholarship that higher education demands on the other. The balance is not always easy to achieve.

In this study we were charged with the task of identifying the educational needs of learning disability and mental health nurses following the community reforms and the NHS & Community Care Act. Our findings will come as no surprise to opinion leaders in the two specialties. Indeed, many may say that we have come up with nothing much that is new. We do not say this as an apology. Rather, what we have shown from this study is the considerable consensus that exists among mental health and learning disability nurses and other stake-holders about good practice and education in the two specialties and the shortcomings within each.

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PHASE 3 ANALYSIS AND MODEL DEVELOPMENT (STAGE 2): THEMES DERIVED FROM INTERVIEWS CONTRIBUTING TO CATEGORIES AND THEMES

APPENDIX 4.1 LOCATIONS OF KEY INFORMANTS

The key informants were drawn from the following organisations and services:

For mental health

Centre for Mental Health Services Development, King's College London
Department of Nursing, University of Manchester
Department of Psychiatry, University of Newcastle
Department of Social Science & Administration
English National Board for Nursing, Midwifery and Health Visiting
Independent mental health consultant and freelance trainer
Institute of Health Care Policy and Ageing Research, New Jersey, USA
Kent Social Services Department
London School of Economics
MIND
North East Thames Regional Health Authority
Pathfinder Mental Healthcare NHS Trust
Riverside Mental Health Trust
Royal College of Nursing Mental Health Nursing Society
Sainsbury Centre for Mental Health, London
Survivors Speak Out
Sydenham Green Health Centre
Trent Regional Health Authority

For learning disability

Centre for Applied Psychology and Social Science, University of Kent
Department of Health
Department of Nursing and Health Visiting, University of Ulster
Department of Psychiatry, University of Newcastle
English National Board for Nursing, Midwifery and Health Visiting
Kent Social Services Department
MENCAP
National Development Team, Manchester
North West Thames Regional Health Authority

Additional key informants interviewed for Stage 2 of the analysis were drawn from :

Department of Nursing and Social Work, University of Middlesex
Department of Nursing Studies, King's College London
Department of Nursing, University of Glasgow
Department of Psychiatry, University of Newcastle
Department of Social Policy and Social Work, University of York
Independent mental health consultant and freelance trainer
Institute of Health Services Management
Institute of Health Studies, University of Plymouth
Institute of Psychiatry, London
Kingston & St George's College of Health Studies
Royal College of Nursing
Welsh Centre for Learning Disabilities

APPENDIX 4.2 THE SITES

The focus and organisational structures in each of the six sites are as follows:

Site 1 mental health

Site 1, in inner city London, consisted of three services: a mental health service, a drop-in community resource centre run by MIND, and a primary care team for homeless people.

The mental health service

Brief description of the service. The service was still in the formative stage at the time of our fieldwork. It was developed in 1993 from an existing community psychiatric nursing team and consisted of a community mental health team with a linked ward in the local psychiatric hospital. The service started as a pilot project, but became relatively permanent when the health service went ahead in setting up similar services in other localities without waiting for the results of this one. The service was part of a directly managed unit (DMU) providing family and community health services; it had not acquired trust status at the time of the study.

The objectives of the service were to:

- shift the emphasis of care from in-patient to community based services;
- create a seamless service ensuring a 24-hour availability to the locality;
- provide a single point of entry to mental health services;
- provide effective liaison and consultation services to other health and social care providers in the locality in order to facilitate a comprehensive care service for the community.

Service priorities were:

- people in acute distress who require intensive, focused, short term interventions, without which hospitalisation may result;
- long term support and rehabilitation of people with enduring needs without which quality of life and functioning could be significantly impaired and relapse likely;
- consultancy work with primary care, offering assessment, guidance and short term, focused interventions to people referred by GPs and others in primary care, who can be treated successfully at home or in the community;

- a central access point to provide the first point of contact for new referrals to mental health services.

The organisational structure of the service. The team was managed by a locality manager who reported to the operations manager for hospital and community mental health services and through her to the head of service, a psychiatrist based at the psychiatric hospital. The team consisted of an administrator, a senior registrar (post vacant), a clinical psychologist (post vacant), an occupational therapist and five community mental health nurses. In-patient care for local residents was provided at the hospital by two consultant psychiatrists and associated teams.

Quality assessment was in an early stage of development; user and carer satisfaction surveys and a referrer satisfaction survey had been conducted and an investigation of suitable clinical outcomes was in progress.

Contracting and purchasing. The budget for the team was held by the locality manager who was responsible to the operations manager. A financial adviser from the DMU was available to help him when needed. The purchasers were the health authority which negotiated the contract with the operations manager.

Links with educational establishments. Medical and nursing students were placed regularly with the team and an occupational therapy student also when available. Links with the local college of nursing were changing because of reorganisation and merging of three colleges. Students from all three colleges who were enrolled on the combined RGN/RMN course were interviewed.

Purpose of the service. To develop and provide a high quality, culturally sensitive mental health service for residents that is accessible, flexible and responsive to the needs of the users of the service.

The MIND drop-in community mental health resource centre

Brief description of the service. The service offered a drop-in centre, stress management, reflexology, a homeopathy clinic, counselling, leisure activities, a carers' group, advice and support.

The organisational structure of the service. It was managed by a care services manager, who, at the time of the study, was on maternity leave. One of the senior project leaders was acting up. The care services manager reported to a management committee. The team consisted of project workers, a counselling service coordinator, a housing support and advice worker, an Afro-Caribbean outreach worker and an administrator.

Quality monitoring consisted of asking all users to complete a referral form containing details of age, gender, ethnic origin, living status, psychiatric history and current contact with psychiatric services. Every three months this information was put through the computer to generate a list of people attending and their progress; for example, whether they were still using the centre, which services they were using, if no longer attending where they had gone, and so on.

Efforts had started to evaluate the quality of the service. They had conducted a survey of users' views in 1993 and were in the process of reviewing their service as a result. They also had a complaints procedure and information was given to users who wished to make a complaint. In the first instance the complaint would be lodged with the staff member's manager and, if it could not be resolved, to the chair of the management committee.

Contracting and purchasing. A service level agreement existed with the local authority who purchased their therapeutic services - counselling, art therapy, movement therapy, women's therapy, reflexology and homeopathy. Funding was also acquired from the health authority and charitable organisations. Different projects had their own budgets held by the worker in charge of the project. For example there was an activities budget, which covered the drop-in service, outings and entertainments. The counselling service and the Afro-Caribbean outreach project had separate budgets.

Links with educational establishments. In the past, students from the local college of nursing had taken up placements but over the past year, with the change to the DipHE curriculum, no requests had been made for similar placements. The college had hoped to send a large number of students on half-day visits, but the centre felt the work required would outweigh any benefit to them. A social work student from a nearby university was working at the centre during our time there, and medical students spent half a day a week there for eight weeks.

Purpose of the service. This was under review. The centre's goals were to cooperate and work with community groups from the statutory and voluntary sectors and to be an effective connecting point and focus for furthering traditional support services for people with mental health difficulties.

The primary care team for homeless people

Brief description of the service. This service consisted of a multi-professional team offering health care, social care and help with housing to homeless people in inner city London. The team provided primary care for single homeless people through sessional work in day centres, hostels and refuges in the voluntary sector. The aim was to enable homeless people to access mainstream medical care. They also did housing and resettlement work, and street work with the aim of engaging with users living on the streets, building a relationship with potential users and giving advice on the services available.

The organisational structure of the service. The service was overseen by a management committee. The team was organised by a team manager and consisted of community nurses, community psychiatric nurses, mental health workers, a clinical psychologist, an alcohol worker, a chiropodist, social worker, resettlement workers, sessional psychiatrists and GPs, and an administrator.

Quality: Evaluation occurred through team meetings and reflective practice. Records were kept on a user database. In 1993 and 1994 the work had been evaluated by the Department of Health's Homeless Mentally Ill initiative.

Contracting and purchasing. The service was funded by several sources: the local London borough, two hospital groups (one now a trust), the FHSA, the health authority and the Department of Health Homeless Mentally Ill Initiative.

Links with educational establishments. Students from the three local colleges of nursing were placed with the team. We interviewed one student who was enrolled on the DipHE course, mental health branch.

Purpose of the service. The service has not articulated a formal approach or set of values except that the team will see any homeless person who wants help, and all people have open access to the service.

Site 2 mental health

This mental health team providing continuing care services was located on the south coast of England.

Brief description of the service. A multi-professional team worked with people up to the age of 65 years who require support with continuing mental health difficulties. The help included: psychiatric, functional and self harm assessment, provision of a range of psychotherapies, complementary therapies, group working, rehabilitation and networking, a depot injection service, and support and advice for carers.

The organisational structure of the service. The team was part of the local health care trust which provided for all aspects of health care. A team coordinator managed the team and reported to the service manager responsible for all the community services in the area. The team consisted of a consultant psychiatrist, senior registrar, social worker, 16 community psychiatric nurses, two occupational therapists, and a psychology assistant with advice from a psychologist.

Contracting and purchasing. The health commission was the main purchaser with whom relations with them are not considered good because, it was said, the commission lacked mental health expertise. Marketing was an issue and it was expected that criteria would soon become outcomes based. There had been criticism of the mental health services from the health commission in the past, who had talked of transferring to another provider. The problem was seen to be to do with management. When the trust was established it produced clearer plans acceptable to the health commission, and the proposed transfer was dropped.

GP fundholders had great influence over the services they provided. They generated only about 2% of the mental health services' income even though more work than this was carried out.

Quality assessment varied across the trust with each team developing its own methods evaluation. The team we worked with followed an audit programme from the health commission rather than developing their own system of internal audit.

Links with educational establishments. The mental health team had very little direct involvement with the local university where nursing education took place, although DipHE common foundation and branch students were placed with them. Students were attached to the user rather than the service. We interviewed two students from the DipHE mental health branch, and one from the joint learning disability/social work diploma course. All three had shared their first year, after which the mental health nursing students continued with the CFP of the DipHE course and the learning disability student started the joint course.

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The service manager chaired the senior nurses' advisory group which included a representative from education. The training officer in the trust and the personnel officer, were responsible for negotiating contracts on training with the local university. At the time of our field work, the mental health service was investigating the post-registration courses available with a view to informing the university of their requirements.

Purpose of the service. A written 'philosophy' covered the whole trust. Its purpose was to meet the individual health needs of local people with the aim of improving the health of the local community. The values of the service focused on the importance of clearly stated, commonly agreed values that emphasised 'people, performance, pounds and partnerships'. The values concerning people referred to respect and sensitivity to all people - patients, users; employees, carers and relatives. Performance values related to achieving desired results, user satisfaction, retaining and winning contracts, innovation and publicity. Efficiency values urged value for money and directing resources to users. Successful partnerships with users and carers were seen as essential together with interdisciplinary team working, collaboration with purchasers, education and research providers, and building links with the community.

Site 3 mental health

This site was located in the north west of England.

Brief description of the service. This site contained a large number of services that were managed within four directorates, one of which covered learning disability services which we explored separately, as Site 6. The adult mental health directorate and the care of the elderly directorate formed Site 3. The services they provided consisted of primary care, community, rehabilitation and specialist teams, day care, respite care, and acute and continuing hospital care.

The organisational structure of the service. The case study formed part of a NHS community services trust that consisted of the following directorates: adult mental health, learning disability (see Site 6), care of the elderly, community, and child health. The adult mental health and care of the elderly directorates together formed the mental health directorate, although the care of the elderly directorate also covered general medical needs.

The adult mental health directorate. Referrals covered three main areas: serious mental illness (e.g. schizophrenia and manic depressive psychosis), primary care referrals (e.g.

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anxiety, severe depression) and referrals for specific psychosis. The service was divided into three sectors with two consultant psychiatrists attached to each.

The services consisted of :

a) Primary care teams - one multi-professional team including health and social services in each sector who focused mainly on working closely with GPs in primary health care. The teams had recently introduced a single line management structure in order to promote more co-ordinated team activity. In the past social services and health care staff each had had their own manager. The new manager of the coordinated structure could have either a health or social services background. Team managers provided a single point of contact for GPs and users entering the service.

b) Psychotherapy service - a range of psychotherapies was offered, including art therapy, family therapy and behavioural therapy. This provision was usually available from the professionals within the primary care teams. Provision available to GPs in each sector was limited by the specific skills of staff within that sector.

Plans had been drawn up to centralise this provision, given support from the purchasers, and a development bid had recently been made for two full-time cognitive therapists. This would promote monitoring of need and referral rates and enable access for all GPs to the full range of psychotherapies on offer.

c) Rehabilitation team - one multi-professional mixed grade community team in each sector worked with people with long-term mental health problems. The teams worked flexibly over a seven-day week and provided on-call cover for users and carers. All staff had undergone training in psychosocial intervention techniques.

The prime function of the team was care co-ordination using a care programme approach framework. Development of the service infrastructure continued to include links and joint initiatives with leisure and education departments, employment initiatives, and liaison with a range of housing organisations promoting imaginative housing schemes and facilities.

The service operated a joint referral system offering one point of access to all facilities on offer. The service was included in the Health of the Nation Guidelines on Good Practice for their work with the seriously mentally ill and utilisation of the care programme approach.

d) Day services - until recently all day services had been located within the day hospital situated in the general hospital, with some sessional work taking place at a separately located community mental health care team. Two day centres moved into the community. One, with a focus on seriously mentally people, was run by the rehabilitation team. It provided flexible, accessible day care and backup for the care management system. The other was developing a similar approach.

Day hospital provision had recently been reduced from a seven to a six day week in response to review findings. This reduction was being monitored to assess its impact. The psychiatric day hospital was a nursing development unit. It was carrying out two funded projects, on clinical supervision in in-patient settings and the role of the clinical nurse specialist in psychosocial interventions.

e) Community drugs/alcohol team - a small multi-professional team provided a district wide service through community and day care based detoxification programmes. The team also provided a needle exchange scheme and worked closely with voluntary and independent sectors and the probation service.

f) Psychology team - a small team consisted of one consultant psychologist, three clinical psychologists, one counsellor and one psychology assistant. The team provided a district-wide service which included neurological assessments. Each of the three clinical psychologists also spend 50% of their time based with the primary care teams accepting referrals through this route.

g) A specialist team, based at the general hospital, worked with people from the South Asian population of the area.

h) In-patient services - acute in-patient wards were attached to each sector.

i) The care programme approach had been established for over a year with the following main features:

- assessment - level 1 (all users referred to the services) and level 2 (users with serious or enduring mental ill-health)
- care co-ordination
- care planning
- discharge from hospital
- quality assurance
- computerisation of records.

The care of the elderly directorate. This directorate looked after people of all ages suffering from dementia. It ran the following services:

a) Community mental health care team - consisted of community psychiatric nurses, social workers, support workers and a clinical nurse specialist. A specialist care team for the needs of people with dementia and their carers had been in operation since April 1994.

b) Two wards in the acute hospital were part of the care of the elderly directorate:

i) A 24-bedded ward for older people with mental health problems - liaised with the community mental health care team, the day hospital and the college of nursing. A key-worker system was in operation and the care programme approach was used. Physiotherapists and occupational therapists were active. A nursing development programme was in operation and a lecturer/practitioner gave training and support to students and nursing staff.

ii) A 10-bedded psychoorganic assessment ward - liaised with the community mental health care team and other agencies both pre- and post-discharge to provide a continuing process of user assessment. An outreach worker provided assessment pre-admission and supported users and carers after discharge. A key- and co-worker system ensured a consistent approach to care. A resource room, shared with the first ward, held books and literature for staff and carers to consult. A ward 'parlour' provided a therapeutic environment for reminiscence, individual and group work. A clinical nurse specialist worked in the ward two days a week to enhance staff development and patient care, and support a framework for clinical supervision.

c) A community hospital contained two 12-bedded wards and a 20-place day hospital:

i) A 12-bedded mixed gender ward provided rotational and respite care for people with dementia. At the time of our fieldwork there were also three long-stay residents. Some informal outreach nursing occurred from the ward to improve communication between staff, patients and relatives.

ii) A 12-bedded mixed gender continuing care ward for people suffering from dementia. Occasional beds were used for medium-stay assessment purposes.

iii) The day hospital catered for the needs of older people with both functional and organic illnesses. It was open five days a week, from 8.30am to 4.45pm. It had

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capacity for 15 ambulance day places plus an extra five day places, for people who attended independently. Approximately 42 people attended each week, the number of days per person being assessed on need. An outreach system supported some 20 people and their carers, and operated one day per week. A relative support group was held monthly. As far as possible, users with similar needs attended on the same days so that they could take advantage of specialist care and therapies, and continuity of care could be promoted.

d) A second community hospital contained two continuing care wards for residents with severe mental illness, and a day hospital on the same site. Both wards were supported by physiotherapy:

i) A 20-bedded mixed gender ward also catered occasionally for users who needed short-term assessment. Residents used the day hospital's facilities too.

ii) A 20-bedded mixed gender ward which included two beds for rotational/respite care; the other 18 were for continuing care users.

iii) The 40-place day hospital operated an outreach system two days a week for pre-admission assessment and continuing support to users and carers. The day hospital was supported by physiotherapy, occupational therapy and creative therapy services.

Contracting and purchasing. Services were purchased by the health authority and by GP fundholders. There was a strong thrust towards meeting the *Health of the Nation* targets and the current community care legislation; the care plan approach and provision of a supervision register. In theory the purchasers took the lead in the development of services; in practice, according to the directorate manager, it was the other way round.

There were strong links between social services, health services and the voluntary sector. A joint strategy with a mental health executive sub-group had a planning function which included representatives from all sectors. Another group liaised with GPs.

Links with educational establishments. Students came for placements from the local college of nursing and the trust provided practitioners to teach on the college's courses. Two groups contained members of the trust and educationists working together: one group was examining DipHE developments; the other planned students' placements. The trust was seen, by the directorate manager and confirmed by the two students we interviewed who were attached to the rehabilitation team, to be more advanced in rehabilitation than the college of nursing. Trust members were very keen to bring the college up to date.

Links with one of the local universities were strong. The Thorne diploma course, on psychosocial interventions, and a complementary in-house course were run by a clinical nurse specialist. There were moves to get this course recognised as part of the BSc degree at the university.

Links also existed with another of the local universities where the Psychiatric Nursing Research and Development Unit had recently been set up. Its aims were to foster the future development of psychiatric nursing into the next century. It was planning to seek research funding to investigate topics related to the theory and practice of psychiatric nursing. Lecturer/practitioners from the PNRDU lead courses in therapeutic skills at the university and offer expert supervision. Plans were in progress develop a masters degree in psychiatric nursing practice. The PNRDU expected to start publication of a regular series of psychiatric nursing research monographs that would disseminate knowledge of developmental projects and good practice.

Purpose of the service. The trust had published a 'mission statement' which aimed to provide high quality and cost effective services in a 'reassuring environment' and to prevent illness, promote health and provide treatment and care that can meet the health care needs of the local population.

In its statement of aims, objectives and benefits to patients there was mention of responsiveness to patients' and carers' needs, of treating patients as people and of involving consumers in measuring, setting and improving standards, but no mention of patients' rights. However, the written 'philosophy' of the rehabilitation team stated that the relationship between staff and users as being one of 'equality and acceptance of different ways in which people express themselves in relation to their own unique circumstances'.

Site 4 learning disabilities

This site was located in middle England.

Brief description of service. The learning disability trust provided services for adults and young people who have moderate to severe learning disabilities. Housing was available for 231 adults with some extra residential care. Seven locally based community teams supported users in residential care and also provided assessment, consultation and therapeutic services to users living at home. A team for crisis prevention, assessment and treatment supported up to 10 individuals through its outreach service and had two places for in-patient admission. A respite care service supported up to 34 adults and a specialist children's service provided respite care for up to 28 young people. A medium secure unit gave care to five people.

The organisational structure of the service. The trust was organised into support and operational functions under the responsibility of the chief executive. The support functions were finance and estates, human resources and information technology, and service development, each headed by a director. The operational functions consisted of health and specialist services, headed by a medical director, and three locality teams, each with a locality manager.

Quality assessment operated through a user profiling system which monitored user need. Information on shared action planning was designed to monitor unmet need but, we were told, not always successfully. Good use was made of information given by the Homes Inspectorate on their registered homes. There were plans to streamline all this information, and to introduce a users' complaints procedure.

Contracting and purchasing. The purchasers were the local health authority, the social services department and the Friendly Society, Housing Opportunities for Learning Disability (HOLD). A recent move had been made into joint commissioning, with the health authority and social services collaborating to appoint a joint commissioner and joint strategy.

Links with educational establishments. Five lecturer/practitioners were jointly funded by the trust and the school of health care studies at a neighbouring university. We interviewed three students enrolled on the BA Nursing (Learning Disability) course.

Purpose of the service. The trust worked to a set of values that focused on respect, individuality and choice for the user, the importance of friendship networks, that everyone is entitled to live as an ordinary person in an ordinary community, and that acknowledged users' existing and potential competencies. Care provision should recognise that all users were entitled to skilled professional services that maximised independence and comfort, that provided advocacy representation outside the service and ensured that the quality of the service was monitored and shortcomings improved.

Site 5 learning disabilities

Site 5 was the first site we visited and was located in inner city London some miles away from Site 1.

Brief description of service. This site was described as a consortium that had been formed into a company limited by guarantee and a registered charity. It developed and managed housing for people with learning difficulties and, at the time of our fieldwork, had 150 licensees and tenants living in 44 properties in the borough.

The organisational structure of the service. The consortium was managed by the executive director, the finance director and the director of support services. A housing manager and contracts manager reported to the three directors. The consortium was overseen by a management committee. Services provided by the consortium included: housing, living support, an employment service, help to integrate into the community, individual service contracts, service brokers, an information service and an advocacy service.

In the south of the borough, the consortium provided support to tenants living in houses in the community. Staff worked flexibly round the clock. The aim was to provide the least intrusive and most appropriate help so that the tenants could enjoy a meaningful and ordinary lifestyle within their local community.

In the north of the borough, services previously provided by the local health authority, which included tenant support, an employment service, a community integration service and service brokerage, had transferred to a range of independent providers. Here the consortium monitored quality and purchased services to meet individual needs identified through individual contracts.

The consortium published a quality charter expressed in language suitable to the user group and with illustrations. The charter contained a statement of intent to service users about housing and support services. It specified how complaints could be made, how house repairs could be arranged, how users would be treated, how they could contact service managers and so on.

Contracting and purchasing. The consortium had negotiated a block contract for the provision of services from the local health authority. It also received funds from the local social services department, from the Department of Health, from the special needs management allowance, from rents, grants and other income generating initiatives. The consortium purchased services from external and internal providers, so took on the mantle of purchaser and provider. The internal providers were directly managed by the consortium.

Links with educational establishments. Close links had been developed with the nearby university and the executive director chaired the programme management committee of the BSc in Nursing and Social Work (Learning Difficulties) run by the university. The consortium funded employees to attend the course. We interviewed one student enrolled on this course.

Purpose of the service. The aim was to enable local people with learning difficulty to lead their own lives, by offering services which ensured dignity, presence and participation in the community, choices and skills. The approach taken was based on O'Brien's 'five accomplishments' (O'Brien 1988) - presence, choice and autonomy, competence, status, participation - which operationalised Wolfensberger's normalisation thesis (1972), later replaced by 'social role valorisation' (Wolfensberger 1983). To achieve this aim the consortium worked in partnership with users, statutory agencies, voluntary organisations and others.

Site 6 learning disabilities

This site was in the north west of England in the same area as Site 3.

Brief description of service. The service was jointly managed by health and social services. The multi-professional team provided residential care, respite care, speech therapy, nursing, a challenging behaviour service, a employment service and day care. During 1992/3 the service provided long term residential care to over 300 people, day time activity support to over 320 young people and adults, and short stay respite care to over 60 families.

The organisational structure of the service. The service was managed by the mental health and learning disability directorates of the community services trust (the same trust as for Site 3), and the local social services department. In day-to-day control was a service manager who managed a range of services for people with learning disability: psychiatry, the assessment team, residential services, day services, the community support team, clinical psychology and speech and language therapy. Each of these services was managed by a team leader, manager or head of department.

With the recent merger of the health and social services learning disability teams, staff from both teams were working alongside each other at all levels. This had given rise to some friction at the start but most of these had been ironed out by the time we arrived. The benefits to working as a single service were seen to include:

- single door access to services
- reduced duplication of work effort
- enhanced communication within the service
- increased flexibility in use of funding
- increased job prospects for people with either health or social service backgrounds.

There was also an increase in responsibility, because the service had become the only service which people with a learning disability could use in the area.

An audit tool was being developed for assessing quality of the service. Both health and social services had a formal complaints procedure; a leaflet detailing the social services procedure was distributed to service users. We were not aware of an equivalent health service leaflet.

Contracting and purchasing. A joint commissioning board, drawn from trust and social services department, met quarterly. This had been recently developed and was said not to be working very well. Health and social services had different expectations, it seems. The health services specified what they expected the consultant psychiatrist, clinical psychologist and nurse to do (to do with health checks, assessment and care management, making sure everyone has a named nurse etc). Social services did not provide a similar specification.

Links with educational establishments. Nursing students, from the same college of nursing that linked with Site 3, worked on placement and the college provided fieldwork advisers. Staff from the learning disability service occasionally taught at the college. We interviewed one student from the DipHE in Professional Nursing Studies course.

A new development, to start in 1995, was a collaboration between the college of nursing and one of the local universities to run a 3-year joint diploma in social work and learning disability. Staff from the service were also involved in post-registration community nurse training at another university.

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Purpose of the service. When the two agencies merged, they identified four principles against which they would measure their work:

- to use all available resources to maximum effect
- to make comprehensive individual service plans available to all
- to create and sustain a culture which supports staff in providing high quality service
- to work in partnership with service users, their family and friends.

APPENDIX 4.3: THE INTERVIEW GUIDES

ENON 1 - service managers and workers

Section 1

A) The organisational structure of the service
(cover with identified manager only)

Cover the following:

1.1 produce an organisational chart (attach to the back of this interview guide)
1.2 links with purchasers and their expectations
1.3 links with educational providers - pre-reg, post-reg, in-service, multidisciplinary
1.4 financial management of the service
1.5 written philosophy of the service
1.6 changes (if any) in the structure of the service to meet the requirements of the NHS & Community Care Act
1.7 audit and quality assurance strategies in place
1.8 policy on user access to records
1.9 complaints procedures
1.10 strategy for identification for community wide needs
1.11 existence of formal policy on advocacy, users' rights and user involvement and provision of information

B) Locating the respondent within the organisation

Cover the following

1.12 job title and grade plus description of service if relevant
1.13 length of time in post
1.14 previous experience
1.15 qualifications
1.16 user groups with whom the respondent works
Probe: How are users classified (e.g. by disorder, by severity, short/long term)
1.17 educational responsibilities
1.18 links with the wider organisation: other professionals (including GPs) purchasers of services, educational providers
Probe: What direct contact do you have with purchasers?

C) The process of user referral management in the service and values clarification

(Purpose of this sub-section is to gain an understanding of the processes of care delivery within the organisation and the values and philosophy which informs that process)

1.19 determine the process of referral, assessment, and management for a 'typical' user/s

Probe: to establish clear understanding of the user's progress through the care systems of the organisation

1.20 respondent's personal values (aim, purpose) in carrying out his/her job (if any).

Probe on: views on advocacy, patients' rights, user involvement.

Section 2 Principal Components of work (up to 4 maximum)

(The purpose of this section is to assist the respondent to identify the main aspects of his/her job, to identify main competencies needed for each aspect, and to assess the extent to which these were acquired through 'formal' educational experiences)

Collaborate with the respondent to help him/her to identify the principal components of their job (up to 4).

Probe

- If necessary ask respondent to take the interviewer through a typical week to identify main aspects of job.
- Include components that are ideal but not practised in the care setting (i.e. address the gap between actual and ideal working practices and structural factors which prevent ideal performance)
- Components of job that have changed since the reforms and those which are the same

2.1A Component A

2.2A The competencies required for successful performance

Note to interviewer: ensure that you understand how each of the competencies identified contribute to successful performance of that job component

Probe:

- address knowledge, skills, and attitudes which the respondent believes are important to the job component

- identify knowledge, skills and attitudes which the respondent believes has mastered and those where is room for improvement.
- explore whether respondent was prepared for new job components

2.3A Acquisition of these competencies and educational implications

- Run through job component to ascertain how competencies (knowledge, skills and attitudes) were acquired;

Probe: establish the contribution of education - past or present - to competency acquisition and respondents views on educational implications

Repeat 2.1A, 2.2A, 2.3A for job component B, C and D

Section 3 Educational experience and its contribution to role performance

Whereas Section 2 moved from the job to the learning experience for it this section takes the respondent in the other direction. The purpose is to assist the respondent to identify his/her educational/learning experiences and to assess the extent to which these contribute to work).

(Reference may be made to Section 2 if answers are repetitive and curtail the section if no new information is forthcoming)

Collaborate with the respondent to help him/her to identify significant experiences related to present work. Draw upon the list of courses provided in advance of interview.

Probe:

Help respondent identify on-the-job supervision and other educational experiences in addition to formal courses.

3.1A Experience of 'formal' education

3.2A What knowledge, skills and attitudes were acquired and how?

Probe for:

- positive and negative aspects of the experience related to knowledge, skill and attitude acquisition
- illustrative examples to help to understand the mechanisms by which the educational experience led to knowledge, skill and attitude acquisition
- knowledge, skill and attitudes which respondent believes has mastered and those not.
- teaching methods

3.3A Ways in which knowledge, skill and attitudes assist respondent in successful performance of components of present job

- only include new information not covered in Section 2;
- probe to identify anything included in the course content which is unnecessary

Repeat 3.1A to 3.3A for other experiences of formal education

Section 4 Other experiences and their contribution to present work

(Identify significant experience which made an impact on your work performance: explore impact on related knowledge, skills and attitudes).

4.1 nature of the experience

A)

B)

4.2 what was important about it and why

A)

4.3 how does this assist you in your work

A)

Section 5 The nature of the respondent's job in relation to other health care professionals

(The purpose of this section is to determine the nature of multidisciplinary team working. In particular the extent to which the boundaries between roles are clear or blurred and the degree to which multidisciplinary education is feasible and desirable).

5.1 who works with most of time in course of work

5.2 benefits of working in this way to user care

5.3 development of this way of working

5.4 reasons for developing this way of working

5.5 difficulties of working in this way

5.6 how respondent has tackled these difficulties

5.7 any other model of care which would be preferable

Probe: implications for role boundaries between workers

Section 6 Aspects of service delivery related to the NHS & Community Care Act (1990)

(The purpose of this section is to examine specific implications of the Act to determine how they have been addressed by the respondent and the service. And to ask the respondent for his/her judgement of the implications for education that arise directly from that aspect of work. Omit aspects that have been addressed by previous questions.)

6 a) Have you any experience of the following issues that have emerged from the Act?

b) If so, what are their educational implications?

6.1 identification of unmet need in the community (e.g. ethnic minorities and transient populations)

+ implications for education

6.2. the needs of priority user groups (people with enduring and serious mental health problems/challenging behaviour)

+ implications for education

6.3 care/case management arrangements and budgetary control

+ implications for education

6.4. process and methods of user assessment

+ implications for education

6.5 community discharge plans (CPA)

+ implications for education

6.6 needs of people from different cultural backgrounds

+ implications for education

6.7 domiciliary, day care and respite services

+ implications for education

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6.8 collaboration between professionals within and between health and social services
+ implications for education

6.9 management of untrained workers
+ implications for education

6.10 support for carers and consultation with users and carers
+ implications for education

6.11 good access to services (advocacy, brokerage, patients' rights and user involvement)
+ implications for education

6.12 provision of information for users and carers
+ implications for education

6.13 multidisciplinary training
+ implications for education

6.14 involvement of private and voluntary sector
+ implications for education

6.15 prevention and identification of mental illness and learning disability by primary health services
+ implications for education

6.16 cost effective resource management
+ implications for education

6.17 strategies for evaluating service
+ implications for education

6.18 knowledge of access to records and ease of access
+ implications for education

Section 7: Additional information

(Any additional information or views contributed by the respondent and not included elsewhere. Make separate points numbered consecutively as needed)

7.1. How do you see your service developing over the next 5 years? [N.B: Distinguish between impact of the service development for users/for workers]

7.2 What are the educational implications of these trends for nurses?

7.3 How do you see the role of the learning disability/mental health nurse developing (over the next 5 years) vis-à-vis that of other professionals?

7.4 Any other information?

ENON Topic Guide 2 - lecturers

Ask lecturer in advance to bring any relevant course documents to the interview

1 Details of courses

1.1 college
1.2 courses offered
1.3 contracts with service providers
1.4 inter-disciplinary (specify disciplines) or unidisciplinary
1.5 number of students and placement locations

2 Nature of course(s) and links between service and education

2.1 Main skills and abilities necessary for working with people in the following groups:

- long-term mental illness
- acute mental illness
- less disabling mental illness
- substance abuse problems
- mild learning disabilities
- severe/multiple disabilities
- challenging behaviour

2.2 Ways in which course(s) help students achieve these skills/abilities
Probe: explore course values, structure, content, process and evaluation.

3 Aspects of education related to the NHS & Community Care Act

3.1 changes in teaching since implementation of the Act
Probe content, process, user involvement

3.2 consideration of the following, with implications for education:

3.2.1 identification of unmet need in the community (e.g. ethic minorities and transient populations)
+ educational implication

3.2.2 the needs of priority user groups (people with enduring and serious mental health problems/challenging behaviour)
+ implications for education

3.2.3 care/case management arrangement s and budgetary control
+ implications for education

3.2.4 process and methods of user assessment
+ implications for education

3.2.5 community discharge plans (CPA)
+ implications for education

3.2.6 needs of people from different cultural backgrounds
+ implications for education

3.2.7 domiciliary, day care and respite services
+ implications for education

3.2.8 collaboration between professionals within and between health and social services
+ implications for education

3.2.9 management of untrained workers
+ educational implications

3.2.10 support for carers and consultation with users and carers
+ implications for education

3.2.11 good access to services (advocacy, patients' rights and user involvement)
+ implications for education

3.2.12 provision of information for users and carers
+ implications for education

3.2.13 multidisciplinary training
+ implications for education

3.2.14 involvement of private and voluntary sector
+ implications for education

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3.2.15 prevention and identification of mental illness and learning disability by primary health services
+ implications for education

3.2.16 cost effective resource management
+ implications for education

3.2.17 strategies for evaluating service
+ implications for education

3.2.18 knowledge of access to records and ease of access
+ educational implications

4 Current challenges and future plans

5 Additional information

(Any additional information or views contributed by the respondent and not included elsewhere. Make separate points numbered consecutively as needed)

5.1 How do you see your service developing over the next 5 years? [N.B. Distinguish between impact of the service development for users/for workers]

5.2 What are the educational implications of these trends for nurses?

5.3 How do you see the role of the learning disability/mental health nurse developing (over the next 5 years) vis-à-vis that of other professionals?

5.4 Any other information?

ENON Topic Guide 3 - users/carers

Section 1 Brief user history and present circumstances

1.1 age
1.2 gender
1.3 marital status
1.4 residence
1.5 periods of hospitalisation - how long in or out of hospital
1.6 length of time with community service
1.7 involvement with staff - key worker, social worker etc
1.8 daytime activity - employment, education, day services
1.9 unpaid carers - family, friends, neighbours

Section 2 Experiences of care

2.1 Reasons for finding staff helpful/less than helpful

Probe:

- expectations of service
- choice of treatment given/not
- outcome
- omitted care (errors of omission)
- care done that shouldn't have been (errors of commission)
- care that could have been done better (adequacy of care)
- satisfaction with care provided
- details of any changes in care provision over time

Section 3 Implications of the Act

3.1 existence and value of care plan

3.1 a) Have you any experience of the following issues that have emerged from the Act?
b) If so, what are their educational implications?

3.2.1 identification of unmet need in the community (user's own needs)
+ educational implication

3.2.2 care/case management arrangement s and budgetary control

+ implications for education

3.2.3 process and methods of user assessment
+ implications for education

3.2.4 community discharge plans (CPA)
+ implications for education

3.2.5 needs of people from different cultural backgrounds
+ implications for education

3.2.6 domiciliary, day care and respite services
+ implications for education

3.2.7 collaboration between professionals within and between health and social services
+ implications for education

3.2.8 support for carers and consultation with users and carers
+ implications for education

3.2.9 good access to services (advocacy, patients' rights and user involvement)
+ implications for education

3.2.10 provision of information for users and carers
+ implications for education

3.2.11 prevention and identification of mental illness and learning disability by primary health services
+ implications for education

3.2.12 knowledge of access to records and ease of access
+ educational implications

ENON Topic Guide 4 - advocates

Section 1 The advocate

1.1 Nature of advocate post and responsibilities
- possibly including description of the service

1.2 Previous experience

Section 2 The user/user group

2.1 Details of user or user group with whom respondent works
- nature and extent of disability;
- personal history (including periods of hospitalisation);
- residential circumstances;
- daytime activity - employment, education, day services;
- unpaid carers - family, friends, neighbours;
- nature of involvement of providers and purchasers.

Section 3 Experiences of care

3.1 Perceived needs and expectations for the user

3.2 Strategies through which the service has enabled the user to achieve these expectations/ meet their needs and the educational implications of these strategies for health care professionals

- strategy 1 + educational implications
- strategy 2 + educational implications

etc.

3.3 Main problems which prevent expectations being achieved or needs met, perceived solution to these problems and their educational implications

- problem 1 + solution/s and their educational implications
- problem 2 + solution/s and their educational implications

etc.

3.4 Do you have a view on whether it is possible and/or desirable for health professionals generally and services particularly to act as advocates?

- educational implications? e.g. how do you train nurses for this role?

Section 4 Implications of the Act

a) Have you any experience of the following issues that have emerged from the Act?

b) If so, what are their educational implications for nursing?

4.1 identification of unmet needs in the community (users' own needs or more broadly

+ educational implications

4.2 care/case management arrangements and budgetary control

+ educational implications

4.3 process and methods of user assessment

+ educational implications

4.4 community discharge plans

+ educational implications

4.5 needs of people from different cultural backgrounds

+ educational implications

4.6 domiciliary, day-care and respite care

+ educational implications

4.7 collaboration between professionals within and between health and social services

+ educational implications

4.8 support for carers and consultation with users and carers

+ educational implications

4.9 good access to services (advocacy, patient's rights and user involvement)

+ educational implications

4.10 provision of information for users and carers

+ educational implications

4.11 prevention and identification of mental illness and learning disability by primary health care services

+ educational implications

4.12 knowledge of access to records and ease of access

+ educational implications

Section 5: Additional information

(Any additional information or views contributed by the respondent and not included elsewhere. Make separate points numbered consecutively as needed)

5.1 How do you see your service developing over the next 5 years? [N.B. Distinguish between impact of the service development for users/for workers]

5.2 What are the educational implications of these trends for nurses?

5.3 How do you see the role of the learning disability/mental health nurse developing (over the next 5 years) vis-à-vis that of other professionals?

5.4 Any other information?

ENON Topic Guide 5 - doctors, other therapists, executive managers, purchasers

Section 1

A) The organisational structure of the service

(cover with identified manager only)

Cover the following:

1.1 Produce an organisational chart (attach to the back of this interview guide)

1.2 Links with purchasers and their expectations

1.3 Links with educational providers - pre-reg, post-reg, in-service, multidisciplinary

1.4 Financial management of the service

1.5 Written philosophy of the service

1.6 Changes (if any) in the structure of the service to meet the requirements of the NHS and Community Care Act

1.7 Audit and quality assessment strategies in place

1.8 Policy on user access to records

1.9 Complaints procedures

1.10 Strategy for identification for community wide needs

1.11 Existence of formal policy on advocacy, users' rights and user involvement and provision of information

B) Locating the respondent within the organisation

Cover the following

1.12 Job title and grade plus description of service if relevant

1.13 Length of time in post

1.14 Previous experience

1.15 Qualifications

1.16 User groups with whom the respondent works

Probe: How are users classified (e.g. by disorder, by severity, short/long term)

1.17 Educational responsibilities

1.18 Links with the wider organisation: other professionals (including GPs) purchasers of services, educational providers

Probe: What direct contact do you have with purchasers?

C) The process of user referral management in the service and values clarification

(Purpose of this sub-section is to gain an understanding of the processes of care delivery within the organisation and the values and philosophy which informs that process)

1.19 Determine the process of referral, assessment, and management for a 'typical' user/s
Probe: to establish clear understanding of the user's progress through the care systems of the organisation

1.20 Respondent's personal philosophy (aim, purpose) in carrying out his/her job (if any).
Probe on: views on advocacy, patients' rights, user involvement.

Section 5 The nature of the respondent's job in relation to other health care professionals

(The purpose of this section is to determine the nature of multidisciplinary team working. In particular the extent to which the boundaries between roles are clear or blurred and the degree to which multidisciplinary education is feasible and desirable).

5.1 Who works with most of time in course of work

5.2 Benefits of working in this way to user care

5.3 Development of this way of working

5.4 Reasons for developing this way of working

5.5 Difficulties of working in this way

5.6 How respondent has tackled these difficulties

5.7 Any other model of care which would be preferable
probe: implications for role boundaries between workers

5.8 How do you see the work of nurses since the community care reforms?

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Section 6 Aspects of service delivery related to the NHS & Community Care Act (1990)

(The purpose of this section is to examine specific implications of the NHS and Community Care Act to determine how they have been addressed by the respondent and the service. And to ask the respondent for his/her judgement of the implications for education that arise directly from that aspect of work. Omit aspects that have been addressed by previous questions.)

6a) Have you any experience of the following issues that have emerged from the Act?
6b) If so, what are their educational implications?

6.1 identification of unmet need in the community (e.g. ethic minorities and transient populations)
+ implications for education

6.2 the needs of priority user groups (people with enduring and serious mental health problems/challenging behaviour)
+ implications for education

6.3 care/case management arrangement s and budgetary control
+ implications for education

6.4 process and methods of user assessment
+ implications for education

6.5 community discharge plans (CPA)
+ implications for education

6.6 needs of people from different cultural backgrounds
+ implications for education

6.7 domiciliary, day care and respite services
+ implications for education

6.8 collaboration between professionals within and between health and social services
+ implications for education

6.9 management of untrained workers

+ implications for education

6.10 support for carers and consultation with users and carers
+ implications for education

6.11 good access to services (advocacy, brokerage, patients' rights and user involvement)
+ implications for education

6.12 provision of information for users and carers
+ implications for education

6.13 multidisciplinary training
+ implications for education

6.14 involvement of private and voluntary sector
+ implications for education

6.15 prevention and identification of mental illness and learning disability by primary health services
+ implications for education

6.16 cost effective resource management
+ implications for education

6.17 strategies for evaluating service
+ implications for education

6.18 knowledge of access to records and ease of access
+ implications for education

Section 7: Additional information

(Any additional information or views contributed by the respondent and not included elsewhere. Make separate points numbered consecutively as needed)

7.1 How do you see your service developing over the next 5 years? [N.B. Distinguish between impact of the service development for users/for workers]

7.2 What are the educational implications of these trends for nurses?

7.3 How do you see the role of the learning disability/mental health nurse developing (over the next 5 years) vis-à-vis that of other professionals?

7.4 Any other information?

ENON Topic Guide 6 - students

1. What course are you undertaking?

2. What clinical placements have you completed on your present course?

3. What are the main advantages and disadvantages of the course that you are doing?

4. What other courses, if any, have you undertaken prior to this one?

5 With respect to your experience of mental health/learning disability nursing, what aspects of:

a) your present course have been particularly helpful to you in caring for users?

In what way have these aspects of the course been helpful?

Any examples?

b) your previous courses have been particularly helpful to you in caring for users?

In what way have these aspects of the course been helpful?

Any examples?

6. Have you had other experiences which come to mind as being particularly important/helpful to you in learning to care for users?

In what way have these experiences been helpful?

Any examples?

7. Have you any experience of the following aspects of service delivery which are highlighted by the NHS & Community Care Act (1990)?
If so what are their educational implication? (even if noted as deficient)

7.1 identification of unmet need in the community?

7.2 the needs of priority user groups (people with enduring and serious mental health problems/challenging behaviour)?

7.3 care/case management arrangements and budgetary control?

7.4 process and methods of user assessment?

7.5 community discharge plans?

7.6 needs of people from different cultural backgrounds?

7.7 domiciliary, day care and respite services?

7.8 collaboration between professionals within and between health and social services?

7.9 management of untrained workers?

7.10 support for carers and consultation with users and carers?

7.11 good access to services (e.g. advocacy, brokerage, patients' rights and user involvement)

7.12 provision of information for users and carers?

7.13 multidisciplinary training?

7.14 involvement of the private and voluntary sector?

7.15 prevention and identification of mental illness and learning disability by primary health care services?

7.16 cost effective resource management?

7.17 strategies for evaluating services?

7.18 knowledge of access to records and ease of access?

8.1. If resources were no problem, how would you like to you see the service developing over the next 5 years?

8.2 What are the main factors influencing this development?

8.3 What are the implications of these developments for the educational preparation of nurses?

9. How do you see the role of the learning disability/mental health nurse developing (over the next 5 years) vis-à-vis that of other professionals?

APPENDIX 5 QUESTIONS ON SERVICE PROVISION EXCLUDING IMPLICATIONS OF THE NHS & COMMUNITY CARE ACT

Here and in Appendix 6 the format to presenting the data is similar. For each question the most frequently endorsed views that emerged are summarised in three tables, where appropriate. The first table contains the views identified by respondents from both specialties. The second table contains views that were more important to mental health respondents, and the third table contains views more important to learning disability respondents. The frequency with which all respondents endorsed each view appears in the first column of each table, together with its percentage. Views that we considered to be important were those endorsed by 7% or more of the respondents. This arbitrary cut off point ensured that the most frequently endorsed views predominated but it also allowed us to give prominence to some of the views considered important by only a few respondents. Where respondent numbers are small, their percentages should be treated with due caution, however.

The tables summarise the views under three headings: aspects of service (structure and process), personal characteristics of practitioners, and educational aspects. Where views do not address one of these headings, the cell in the table is left blank. The frequency with which views were endorsed by site and occupational group are listed after each table. Some of these frequencies are extremely small; we include them because they were important to the respondents who expressed them nonetheless.

The questions in Appendix 6 concentrate on issues relating to the implementation of the NHS & Community Care Act. In this appendix the questions probe other areas of service provision, that is: respondents' perceptions of models of care provision and the future of services in mental health and learning disability nursing since the Act and community care reforms. Also, multi-professional working and the role of mental health and learning disability nurses, and issues related to advocacy. Students were also asked about their experiences of their courses.

A5.1 Models of care (Question W5.7 and D5.7)

Table 5.1 Views shared between mental health and learning disability:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 2 MH 12 (18) LD 13 (32)	The quality of multidisciplinary teamwork is crucial to effective services Cohesive and on-the-spot working enables effective open access and referral systems to operate well.	Flexible, adaptive non-territorial and committed to cohesive multidisciplinary working	To ensure broad understanding of the scope of service provision and challenges to multidisciplinary working and how these may be met
V 13 MH 9 (14) LD 5 (12)	Services develop and test imaginative models of service delivery for their potential to meet client needs.	Flexibility, creativity and confidence to try out new ideas.	Education to encourage critical appraisal of service delivery grounded in clinical experience. Creativity, innovation to be encouraged.

(in this and subsequent tables, MH - mental health, LD - learning disability)

View 2

This view was mainly expressed by MH respondents from Site 3 (6) and Site 1 (5). Six workers and 6 managers/other professionals endorsed this view.

Across LD sector respondents this view was primarily an issue for those from Site 4 (9). Two responses each were obtained from Site 5 and Site 6. This was primarily an issue for managers/other professionals (11). Workers numbered 2.

View 13

This view was most popular amongst MH Site 2 (4) and Site 3 respondents (3). Two responses came from Site 1. For MH respondents managers/other professionals numbered 7 whilst workers numbered 2.

For LD this view was mentioned mostly by respondents from Site 5 (4), of whom 3 were managers/other professionals and 2 were workers.

Table 5.2 Views more important to mental health:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 4 MH 4 LD 0	Multidisciplinary teamwork may often exclude users from decision making.	Commitment to promoting user empowerment and involvement in running mental health services	Principles of user choice and empowerment receive priority as do examples drawn from practice of how choice and power may be exercised.

View 4

This view was expressed by a few MH respondents: 2 from Site 1 and 2 from Site 2. Three 3 managers/other professionals and 1 worker identified it.

Table 5.3 Views more important to learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 11 MH 0 LD 3 (7)	Specialist service provision for LD have many advantages but can effectively prevent clients from accessing mainstream services thereby increasing stigma and social exclusion.		Education to highlight potential conflicts in pursuing principles of care, in this case, high quality care provision and social integration.

View 11

This view was endorsed by 1 LD respondent from each site, 2 of whom were managers/other professionals and 1 a worker.

A5.2 Multidisciplinary working (Questions W5.2 - W5.6, D5.2 - D5.6)

Table 5.4 Views shared between mental health and learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 1 MH 19 (29) LD 13 (31)	Written and spoken communication within team and with outside agencies for interdisciplinary working and networking	Openness, not resistance, to change, keeping up to date	Skills in interviewing and listening
V 11 MH 18 (28) LD 11 (26)	Strong leadership and management to respect uni-professional cohesion and ensure client-led practice	Supportive leadership	Strong uni-professional identity remains a priority
V 6 MH 13 (20) LD 8 (19)	Collaborative working enhances efficiency and effectiveness of the care process by pooling skills	Recognising the sense of empowerment that occurs with weak professional boundaries	Shared learning to enhance knowledge and respect for different professions
V 7 MH 13 (20) LD 7 (17)	Inefficiency can be a consequence of blurred boundaries	Respect for responsibilities of each team member and avoiding territorial defensiveness	Shared learning whilst avoiding jacks of all trades. Clinical supervision a priority
V 2 MH 23 (35) LD 16 (38)	Organisational and client focus for effective interdisciplinary working	Flexibility and openness to multidisciplinary working	Information on contribution of other professions and agencies
V 10 MH 11 (17) LD 13 (31)	Multidisciplinary working ensures a variety of skills is available	Increase in repertoire of skills	Learning is a continuing process
V 5 MH 10 (15) LD 5 (12)	Multidisciplinary working is a requirement for effective community care reform	Flexibility and openness to multidisciplinary working	Shared learning on the community reforms and legislative changes
V 4 MH 13 (20) LD 4 (10)	High quality of care from a multidisciplinary input	Growth in knowledge base from many disciplines	Learning and seeking knowledge from colleagues from different disciplines
V 3 MH 8 (12) LD 9 (21)	Relationship building receives priority in effective collaborative working	Allegiance to team membership rather than to a single profession	Shared learning to break down unnecessary professional boundaries
V 9 MH 2 LD 1	Interdisciplinary working empowers members to challenge working practices	Assertiveness and knowledge to challenge other views	Research knowledge and skills a priority
V 8 MH 2 LD 2	Interdisciplinary working promotes creative pooling of ideas	Divergent thinker	Open-minded and creative learning

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View 1

This view was expressed by a high proportion of MH and LD respondents. Across MH sites it was endorsed by 7 respondents from Site 1, 6 from Site 2 and 6 from Site 3. For MH managers/other professionals and workers the responses were 12 and 7 respectively.

For LD sector services this view was expressed by 6 respondents from Site 4, 3 from Site 5 and 4 from Site 6. In terms of respondent type this view was expressed by 8 managers/other professionals and 5 workers.

View 11

Across MH services this view was mainly an issue for Site 2 (8) and Site 1 (7). It was also expressed by 3 respondents from Site 3. It was primarily an issue for managers/other professionals (13) and 5 workers.

For LD sector respondents this view was expressed mostly by those from Site 6 (6). It was also endorsed by 3 respondents from Site 5 and 2 from Site 4. Eight were managers/other professionals and 3 were workers .

View 6

For MH sites this view was predominantly an issue for respondents from Site 3 (7). A further 3 responses each came from Sites 1 and 2. It was expressed by 7 managers/other professionals and 6 workers.

This view was less important to the LD services except for Site 6 (3). Three responses came from Site 4 and 2 from Site 5. It was expressed by 5 managers/other professionals and 3 workers.

View 7

For MH services this view was not particularly popular with respondents from Site 1, but there were 6 responses from Site 3 and 4 from Site 2. It was expressed by 9 managers/other professionals and 4 workers.

This view was a more important issue for the LD Site 4 (6) with 1 response from Site 6. It mostly concerned managers/other professionals (6).

View 2

For MH this view was primarily an issue for respondents from Site 1 (14) and Site 3 (6) with 3 responses from Site 2. It was expressed by 17 managers/other professionals and 6 workers.

For LD respondents there were 6 responses from Site 4, 4 from Site 6 and 3 from Site 5. It was expressed by 11 managers/other professionals and 5 workers.

View 10

This view was only expressed in 2 of the 3 MH sites. Eight responses came from Site 1 and 3 from Site 3 . This was an issue mainly for managers/other professionals (9).

For LD respondents this view was expressed by 6 from Site 4, 5 from Site 5 and 2 from Site 6. It was identified by 9 managers/other professionals and 4 workers .

View 5

This view was most popular in 2 MH sites: there were 5 responses from Site 3 and 4 from Site 1. It was expressed predominantly by workers (7) with 3 responses from managers/other professionals.

This view was expressed in 2 of the 3 LD sites: 3 responses from Site 4 and 2 from Site 5 of whom 1 was a worker and 4 managers/other professionals.

View 4

This view was endorsed in all 3 MH sites: there were 6 responses from Site 1 and 4 from Site 3 and 3 from Site 2. It was expressed by 8 workers and 5 managers/other professionals.

For LD this view was predominantly raised by respondents from Site 4 (6). Two responses came from Site 5 and 1 from Site 6. It was endorsed by 2 managers/other professionals and 2 workers.

View 3

For MH this view was an issue for respondents from Site 1 (6) and Site 3 (2). It was endorsed by 5 workers and 3 managers/other professionals.

For LD this view was endorsed by 9 respondents from Site 4, 4 respondents from Site 6 and 3 from Site 5. Only 1 worker identified it whereas 8 managers/other professionals did.

View 9

This view was expressed by only 2 MH respondents and 1 from the LD sites. All three responses came from managers/other professionals.

View 8

This view was expressed by only 2 respondents from MH and 2 from LD. In both cases there was a single response from a worker and manager/other professional.

Table 5.5 Views more important to learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 12 MH 0 LD 5 (12)	Interdisciplinary team working enhances a holistic view of clients		Shared learning for holistic care
V 13 MH 0 LD 1	Interdisciplinary disagreements cause contradictory care practices	Recognises the importance of effective liaison	Shared learning to enhance compatible decision making and avoid contradictions
V 14 MH 0 LD 1	Danger of territorial disputes in multidisciplinary team working	Territorial defensiveness	Training in management skills a priority

View 12

This view was expressed by LD respondents primarily from Site 4 (3). Single responses came from Site 5 and Site 6. Three workers and 2 managers/other professionals raised it.

View 13

This view was identified by only 1 LD respondent from Site 5 who was an 'other professional'.

View 14

This view was mentioned by one learning disability respondent only, an 'other professional' from Site 5.

A5.3 Who respondent works with most of the time (Question W5.1, D5.1)

This question was only asked of workers and managers/other professionals and enquired as to the other professionals they worked with most of the time. Contact refers to the other professionals who either the worker or manager/other professional worked with. MH-W and LD-W indicate mental health workers and learning disability workers, and MH-M and LD-M refer to mental health managers/other professionals and learning disability managers/other professionals respectively.

Table 5.6 Mental health sites:

Contacts	MH - W	MH- M
Doctors (includes GPs, psychiatrists and others)	12	14
Nurses (includes CPNs, other community nurses, psychiatric nurses and practice nurses)	14	21
Other professionals (includes occupational therapists and other therapists, social workers, and psychologists)	17	14
Managers (from health and social services)	1	11
Purchasers	0	1
Other workers (includes health care assistants, voluntary sector workers, support workers, local authority staff and others)	9	5
Users	0	2

Table 5.7 Learning disability sites:

Contacts	LD - W	LD- M
Doctors (includes GPs, psychiatrists and others)	8	13
Nurses (includes CPNs, other community nurses, psychiatric nurses and practice nurses)	4	13
Other professionals (includes occupational therapists and other therapists, social workers, and psychologists)	12	21
Managers (from health and social services)	0	4
Purchasers	0	1
Other workers (police, probation service, courts, support workers, service brokers, pharmacists, employment agencies, resettlement officers, local authority staff, health service statisticians and computer personnel, bank managers and accountants)	7	16
Users	2	1
Educationalists	0	1

These figures indicate that MH workers came into contact mostly with doctors, other nurses and other professionals. A similar pattern can be seen for MH managers/other professionals who also had contact with other managers (from health and social services).

Learning disability workers had most contact with other professionals. They had less contact with doctors and other workers. Managers/other professionals claimed most contact with other professionals, workers, doctors and nurses.

A5.4 The future of service provision (Question W7.1, W7.2, V 4, V 5.1, V 5.2, A5.1, A5.2, D7.1, D7.2, S8.1, S8.2 and S8.3)

Table 5.8 Shared between mental health and learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 2 MH 25 (31) LD 10 (18)	Nurses taking on social and health care roles within community services in which local authority social services departments are lead providers.	Nurses able to take on valued roles within local authority led services and to share a common understanding of principles and the social and political context of service delivery.	Current nurse education is viewed as inadequate by local authority providers. Suggestions include increased opportunities for shared training and increased emphasis on social policy.
V 1 MH 24 (30) LD 19 (34)	The development of case management and cost-efficient and competitive services. Nurses moving away from a direct care role to the management of people and systems.	Proactive and market oriented.	Education should emphasise: budgeting and accounting; management of semi-skilled workers; skills of case and care management; marketing services.
V 4 MH 24 (30) LD 7 (13)	Community services develop at the expense of residential services. Danger of decline in residential care standards.	Nurses are able to work effectively in community based services in which case management is the predominant form of work organisation. Nurses have good understanding of systems of care delivery.	Increased need for up-skilling courses for nurses moving from residential to community based services.
V 11 MH 13 (16) LD 4 (7)	Future services require highly skilled nurses able to plan and deliver therapeutic interventions.	Nurses are able to provide specialist therapies to clients	Greater emphasis required on post-registration training to provide nurses with specialist therapy skills
V 17 MH 12 (15) LD 7 (13)	High quality services need effective clinical assessment strategies which incorporate a clear role for service users. Clinical assessment to be incorporated within service audit programmes and to address the quality of professional-user relationships.	Nurses to appreciate the importance of ongoing clinical assessment and the contribution of users.	Educationists to collaborate with service providers to develop clinical assessment strategies, which incorporate users' views, and test them in practice.
V 13 MH 8 (10) LD 6 (11)	Community services will increasingly be the primary site of nurse training rather than the hospital ward	Nurses to appreciate the value of training in a broad range of service settings within and outwith statutory services	Increased development of placements outside hospital settings to reflect the move to community care that has taken place. Development of supervision methods which enable students to take on increased responsibility for users
V 7 MH 8 (10) LD 6 (11)	Service development is uncertain. The predominant social care model in which local authority social services departments take lead responsibility for service provision may give way in time to a health and illness oriented service. This may mean the development of care coordination as a separate service.	Nurses recognise and value the biomedical traditions of the profession and be aware of trends in service development.	Education programmes to reflect biomedical tradition of nursing: emphasis on relevant aspects of neuropsychiatry, anatomy and physiology.

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View 2

This view was endorsed mostly by respondents from Site 1 (15); also by 6 respondents from Site 3 and 2 from Site 2. It was predominantly an issue for managers/other professionals (16), workers (6) and lecturers 3.

Ten LD respondents endorsed this view; 5 from Site 4, 3 from Site 5 and 2 from Site 6. It was mainly an issue for managers/other professionals (6) and lecturers (3).

View 1

This view proved particularly popular with respondents from Site 3 (11), with 7 responses from Site 1 and 6 from Site 2. It was mainly an issue for managers/other professionals (15) and workers (6). Two responses were received from lecturers and one student group.

This view was equally important to LD respondents with particular interest shown by Site 4 (12) and Site 6 (6). One response came from Site 5. It was important for managers/other professionals (13), workers (3), 2 lecturers and a student group.

View 4

This view was particularly popular amongst respondents from Site 3 (11) and Site 1 (10). Three responses came from Site 2. For MH respondents it was expressed by 17 managers/other professionals, 5 workers and 2 lecturers.

For LD this view was endorsed by 6 respondents from Site 4 and 1 from Site 6. There were 3 responses each from managers/other professionals and workers and 1 lecturer.

View 11

This view was endorsed by all 3 MH sites: 6 responses from Site 1, 4 from Site 2 and 3 from Site 3. It concerned managers/other professionals (8), lecturers (3), a worker and a student group.

This view was important to LD respondents. There were 2 responses from Site 4 and one each from Site 5 and 6. It concerned mainly managers/other professionals (3).

View 17

This view was expressed by a few MH respondents, particularly in Site 1 (5) and Site 3 (5). The remaining 2 responses came from Site 2. It was mainly an issue for managers/other professionals (9), with 2 responses from workers and one from a lecturer.

Similarly for LD respondents. There were 4 responses from Site 4, 2 from Site 6 and 1 from Site 5. Again this was primarily an issue for managers/other professionals (5), with single responses from a worker and a lecturer.

View 13

This view was expressed by 3 MH respondents from Site 1, 3 from Site 3 and 2 from Site 2. It concerned 3 managers/other professionals, 2 workers, 2 student groups and 1 lecturer.

For LD respondents it was most popular amongst those from Site 4 (4). Single responses came from Site 5 and Site 6. There were 2 responses from managers/other professionals and workers, and single responses from a lecturer and a student group.

View 7

For MH there were 3 responses each from Site 2 and Site 3, and 2 responses from Site 1. This view was equally endorsed by lecturers and workers (2 each) and 4 managers/other professionals.

For LD there were 4 responses from Site 4 and 2 from Site 6. This view was mainly an issue for managers/other professionals (5).

Table 5.9 Views more important to mental health:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 9 MH 14 (18) LD 2	Services for users with challenging behaviour or long-term mental health problems will shape the future direction of community based services.	Nurses are committed to working with these client groups.	Preparation of nurses to work with these priority groups is crucial.
V 20 MH 12 (15) LD 3	Stronger links between specialist and primary health care and specialist MH and LD services are likely and desirable. They would have benefits for cross-professional/agency collaboration and promote a more holistic service for users.	Nurses appreciate the benefits of an integrated service incorporating primary and specialist elements. Are aware of the impact of the service on the nursing role.	A critical consideration of models of service development
V 14 MH 11 (14) LD 3	Services will be increasingly individualised, culturally specific more generally responsive to user choice. Nurses should encourage users to express their preferences and develop services to be responsive to them.	Nurses to recognise the importance of services being sensitive to user choice and providing culturally sensitive services	Principle of user choice to how this can be promoted should feature prominently in education programmes as should an understanding of cultural diversity.
V 10 MH 6 (8) LD 1	Advocacy becomes increasingly important and advocates are involved as a matter of course in user assessment and evaluation	Nurses appreciate and understand the role of advocates and consider moving into that role	The principles and practice of advocacy should be reflected in pre-registration programmes. Nurses interested in developing their advocacy role should take a post-basic advocacy course.

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View 9

This view was mainly an issue for respondents from Site 3 (9) and Site 2 (4). A single response came from Site 1. It was expressed only by managers/other professionals (9) and workers (5).

View 20

This view was expressed in all 3 MH sites, in particular by 5 respondents from Site 3, 3 respondents from Site 2 and 4 from Site 1. It was an issue for managers/other professionals (9) and workers (3).

View 14

This view was mainly an issue for respondents from Site 1 (8) with 2 responses from Site 3 and 1 from Site 2. It was important for managers/other professionals (8), 2 workers and 1 student group.

View 10

This view was expressed by 2 respondents from each of the MH sites, 4 of whom were managers/other professionals and 2 student groups.

Table 5.10 Views more important to learning disability:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 8 MH 4 LD 8 (14)	Audit is integral to high quality services	Nurses aware of the need to set standards in collaboration with other disciplines and evaluate the extent to which they are achieved	Clinical audit is emphasised within education programmes

View 8

This view was expressed by 6 respondents from Site 4 and 2 from Site 6, most of whom were managers/other professionals (5). The other responses came from workers (2) and a lecturer.

A5.5 The developing role of the mental health and learning disability nurse (Question W7.3, V 5.3, A5.3, D7.3 and S9)

Table 5.11 Views shared between mental health and learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 1 MH 17 (21) LD 13 (24)	Nurses must find a distinctive role as individuals and as a professional group within services	Flexible, adaptive and non-territorial	To ensure broad understanding of the scope of service provision. Specialist provision.
V 2 MH 12 (15) LD 7 (13)	Nurses will develop specialist knowledge and responsibilities	Interested in developing a clinical specialism	Pre-registration courses to incorporate clinical specialisms. Post-registration courses available to meet the demand for specialist educational provision e.g. challenging behaviour, forensic psychiatry
V 9 MH 6 (8) LD 4 (7)	Nurses seen as often working in isolation from other health workers. In future must be collaborative. Will move away from traditional hands-on care role towards case and care coordination.	Willing to relinquish traditional hands on care and be more involved in managing services and contributing to care networks.	Educational provision to incorporate: care and case management; supervision of other workers; networking skills

View 1

This view was popular across all three MH sites but in particular there were 10 responses from Site 1 and 5 from Site 3. Another 2 responses came from Site 2. Eleven managers/other professionals and 3 workers identified this view. There were single responses from a lecturer, an advocate and a student group.

For LD respondents this view was particularly an issue for Site 4 respondents (9), and 3 Site 6 respondents. It was identified by 5 lecturers and 8 managers/other professionals.

View 2

This view was identified by equal numbers (4) in all three MH sites. It was primarily an issue for managers/other professionals (9) with some 2 responses coming from workers, and a student group.

For LD this view was picked up by 3 respondents from Site 6, 3 from Site 4 and one respondent from Site 5. It was identified by 3 managers/other professionals, 2 workers, a lecturer and a student group.

View 9

For the MH sites this was mainly an issue for Site 1 (4), with single responses from Sites 2 and 3. For LD this view was endorsed mainly by Site 4 respondents (3) with one response from Site 6.

The MH respondents were 4 managers/other professionals and 2 workers. The LD respondents were 3 workers and 1 student group.

Table 5.12 Views more important to mental health:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 5 MH 7 (9) LD 3	Services will employ increasing numbers of unqualified and vocationally trained (e.g. NVQ) people to give direct care to MH service users.	MH nurses to be able to supervise a less qualified workforce to ensure high quality care for users	Clinical supervision, based on a sound clinical knowledge base, to be a central feature of pre-registration training.
V 6 MH 7 (9) LD 3	Personnel within mental health care teams take on more generic roles. Nurses move beyond a concern with health to undertake aspects of current social work roles.	Nurses are able to provide holistic care for clients within their communities	A broad based education which goes beyond a concern with health and health care to incorporate social assessment and interventions
V 3 MH 6 (8) LD 3	Services will not employ generically trained nurses who are unable to make a distinct and valued contribution to care.	Generic pre-registration is de-skilling	A system of pre-registration nurse education will have negative consequences for MH nurses

View 5

For MH respondents, this view was endorsed by 4 from Site 1, 2 from Site 2 and 1 from Site 3. It was an issue for managers/other professionals (4), workers (2) and an advocate.

View 6

For MH sector there were 3 responses from Site 1 and 3 from Site 3. This issue was expressed by managers/other professionals (3) and student groups (2), a worker and a lecturer.

View 3

The MH respondents who endorsed this view were mainly from Site 3 (5). The 6 responses were expressed by managers/other professionals and workers.

Table 5.13 Views more important to learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 7 MH 5 LD 5 (9)	The focus of attention of LD nurses is health care needs of clients	LD nurses are primarily concerned with clients' health status and ways in which the negative impact of illness and handicap can be lessened	Most training for LD nurses should be health related and focus on illness and handicap.

View 7

There were 2 responses from LD Site 4 and 2 from Site 6. Only managers/other professionals (3) and workers (2), endorsed this view.

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A5.6 Perceptions of the work of nurses since the community care reforms (Question D5.8)

Members of other professions than nursing (doctors, therapists, managers and purchasers) were asked for their views of nursing work since the community care reforms.

Table 5.14 Shared between mental health and learning disability:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 11 MH 9 (22) LD 6 (23)	A more holistic approach including principles of social work	Willing to take a more holistic approach to client care	Shared learning to understand principles of social work
V 6 MH 8 (20) LD 5 (19)	As therapeutic specialists	Willing to take on the responsibility of specialist therapist	Education for therapeutic roles is a priority
V 10 MH 7 (17) LD 5 (19)	Unchanged		
V 7 MH 7 (17) • LD 4(15)	Management of clients' physical as well as mental problems	Recognise the importance of medical knowledge to client care	Medical sciences should remain integral to nurse education
V 9 MH 5 (12) LD 7 (27)	As care managers or care coordinators	Willing to accept responsibilities involved in care management or coordination	Education for care management, supervision and key working a priority
V 25 MH 4 (10) LD 3 (12)	As a generic community carer	Able to justify a distinct nursing role if CPNs do not want to become generic workers	Prepared to educate for genericism unless a distinct CPN role is defined

View 11:

Site responses: Site 1 = 4, Site 2 = 1, Site 3 = 4; Site 4 = 4, Site 5 = 1, Site 6 = 1.

View 6

Site responses: Site 1 = 3, Site 2 = 3, Site 3 = 2, Site 4 = 3, Site 5 = 2.

View 10

Site responses: Site 1 = 4, Site 2 = 2, Site 3 = 1, Site 4 = 3, Site 6 = 2.

View 7

Site responses: Site 1 = 2, Site 2 = 3, Site 3 = 2, Site 4 = 2, Site 5 = 2.

View 9

Site responses: Site 1 = 2, Site 2 = 2, Site 3 = 1, Site 4 = 6, Site 5 = 1.

View 25

Site responses: Site 1 = 1, Site 2 = 2, Site 3 = 1, Site 4 = 1, Site 5 = 2.

Table 5.15 Views more important to mental health:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 20 MH 7 (17) LD 2 (8)	The move from hospital to community care requires nurses to be competent in the care programme approach		Competence in the CPA is a priority for education
V 3 MH 7 (17) LD 0	Need for support groups for nurses to help cope with heavy workload	Assertive about the need for support	Recognition of the importance of support groups and training to support colleagues
V 5 MH 5 (12) LD 1	Multi-agency referral to avoid crises.	Prepared to seek help to prevent crises - proactive	Shared learning on the knowledge and skills of other professionals so able to call on others to prevent crises

View 20

Site responses: Site 1 = 3, Site 2 = 2, Site 3 = 2.

View 3

Site responses: Site 1 = 3, Site 2 = 2, Site 3 = 2.

View 5

Site responses: Site 1 = 4, Site 2 = 1.

Table 5.16 Views more important to learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 15 MH 2 LD 4 (15)	As specialists within community mental health care teams	Willing to take on a highly qualified specialist role	Enabling CPNs to become specialist providers of care in CMHCTs

View 15

Site responses: Site 4 = 2, Site 5 = 2.

A5.7 Reasons for finding staff helpful/less helpful (Question C2.1)

Twelve users/carers were asked if they had found nursing staff helpful, or less helpful, in their care.

Table 5.17 Shared between mental health and learning disability:

View ID freq. (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 6 MH 2 LD 2	CPNs to give practical help	Practical outlook	Practical skills such as letter writing, form filling, dealing with other agencies etc.

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Table 5.18 Views more important to mental health:

View ID freq. (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 3 MH 3 LD 0	Questions how much control the clients should have in determining whether they take their medication	Negotiation skills	Should clients have the right to decide such issues. What to do in cases of non-compliance
V 10 MH 3 LD 1	Giving clients information on local services and resource availability	Good networking	Obtaining broad knowledge of community services and facilities

A5.8 Experiences of care: advocates' perceptions (Question A3.1, A3.2, A3.3)

The four advocates interviewed were asked for their perceptions of their clients' experiences of care provision.

Table 5.19 Shared between mental health and learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 10 MH 1 LD 1	Nurses as advocates must understand the need for an independent and unbiased approach	Appreciate that, to be a successful advocate, outsider help is important for unbiased information	Ensure the intricacies of the advocacy role are understood

Table 5.20 Views more important to mental health:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 5 MH 2 LD 0	Active listeners	Pay more attention to listening and attending to clients however trivial	Emphasise during training the importance to users of seemingly trivial needs and emotions
V 8 MH 2 LD 0	Create a trusting relationship with clients	Recognise the need to work at creating a relationship of trust with clients	Principles and practice of inter-personal relationships a priority
V 9 MH 2 LD 0	Lack of time and funding for advocates	Appreciate the value of advocates	Shared learning to appreciate the value and role of advocates and how best to maximise their contribution to client well-being
V 1 MH 1 LD 0	Information sharing is a major factor in empowering users	Not good at sharing information	Open and frank communication with clients that ensures their involvement in care can be taught
V 2 MH 1 LD 0	User involvement in care	Not always willing to involve users in care	Emphasise the importance of including the user in care
V 3 MH 1 LD 0	Value of social and psychological models of care as well as the medical model	Open minded to different models of care	The relevance of a range of models of client care is a priority
V 4 MH 1 LD 0	Operate as a key worker	Understand and adopt the key worker role	Shared learning to understand the key worker role and the range of services available for referral
V 6 MH 1 LD 0	Value of ex-users as advocates	Recognise that ex-users, who do not have professional training, may be ideal advocates	Debate the pros and cons of professionals or ex-users taking the advocacy role
V 7 MH 1 LD 0	Thorough understanding of services available and how to network effectively	Appreciate they need to know how to get information and how to network	Shared learning to acquire a comprehensive knowledge of the services available and the skills of networking

Table 5.21 *Views more important to learning disability:*

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 11 MH 0 LD 1	Care assistants need training to avoid them having unrealistic expectations	Recognise the training needs of care assistants	Include strategies for meeting care assistants' in-service training and development needs
V 12 MH 0 LD 1	Poor relationships with primary health care services	Recognise the value of effective liaison with primary health care services	Shared learning so that professionals in community health care, social services and primary health care achieve effective interdisciplinary liaison
V 13 MH 0 LD 1	Care assistants feel undervalued by care managers	Fail to recognise the contribution made by care assistants	Training and refresher courses for care managers in team building and effective communication is a priority
V 14 MH 0 LD 1	Inflexible, inappropriate services result in high levels of inactivity for profoundly disabled clients	Recognise the importance of transferring the positive features of institutional life to the community	Training in therapeutic activities specific to profoundly disabled clients is a priority

A5.9 Health professionals as advocates (Question A 3.4)

The four advocates interviewed were asked for their views on the possible role of nurses, and other health professionals, as advocates for clients. Three views were identified all of which were endorsed by MH respondents only (Table 5.22). The single LD respondent interviewed did not express a view.

Table 5.22 *Views more important to mental health:*

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 2 MH 2 LD 0	Advocates should be represented within service structures but should be totally independent from care delivery. CPNs have a role in identifying those clients who require this service.	Nurses recognise that their potential as advocates is limited. They perceive independent advocates as a potential source of service quality improvement - rather than simply a source of criticism.	Education should encourage positive attitudes towards independent advocates; stress the role of the nurse in identifying and referring clients in need.
V 1 MH 1 LD 0	Advocates should be represented within service structures but should be totally independent from care delivery	Nurses recognise that their potential as advocates is limited. They perceive independent advocates as a potential source of service quality improvement - rather than simply a source of criticism.	Education should demonstrate the need for independent advocates for clients.
V 3 MH 1 LD 0	Nurses should act as advocates for clients.	Advocacy seen as a central feature of the nursing role - taking sides with the relatively powerless user against the health and social care system	Education programmes to: emphasise the potential and challenges of the nurses' advocacy role. To address interpersonal and organisational communication skills.

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A5.10 Advantages and disadvantages of course (Question S3)

This question was asked only of students who were interviewed in groups, one group per site. For the purpose of reporting the number of respondents who contributed to a view, we counted the group rather than the individual student. The number of students per group varied across the sites, from six in Site 1 to one in Sites 5 and 6.

Table 5.23 Views shared between mental health and learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 3 MH 3 groups LD 1 group	Opportunity for specialist training varies between certificate, diploma and degree courses	Help students to make an informed choice on which branch of nursing to specialise in	Flexibility needed in enabling students to make the right choice on which branch of nursing to specialise in
V 5 MH 3 groups LD 2 groups	Nursing placements are too short and lack continuity unlike social work placements	Help students to make their placements a worthwhile learning experience	Ensure placements are long enough to promote continuity and be a worthwhile learning experience
V 6 MH 3 groups LD 1 group	The CFP is oriented to general nursing and does not prepare students for their branch	Help students to make the most of the CFP with respect to mental health and learning disability	Consider changing the balance between the CFP and the branch programme
V 7 MH 2 groups LD 1 group	Inadequate liaison by college lecturers with students on placement	Recognise the importance of liaising closely with college lecturers so that students' placement experience is educationally strong	Importance of college lecturers working with students on placement and liaising closely with practitioners so that the placement is a good educational experience

Table 5.24 Views more important to mental health:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 4 MH 2 groups LD 0	Problem of a theory-practice gap between college and practice placements in nursing	Willingness to get up to date on developments in nursing	Reducing the theory-practice gap between college and practical placements is a major priority for nursing education
V 8 MH 2 groups LD 0	Lack of liaison and academic equivalence between university-based and school of nursing-based teaching		Working to bring all pre-registration education to an equivalent level, whether based in university or school/college of nursing, is a priority
V 9 MH 2 groups LD 0	Pros and cons of client allocation rather than practice placements	Willing to support students with their own caseloads	Flexibility towards methods of gaining experience in practice so that students can benefit from the continuity and autonomy offered by client allocation

A5.11 Aspects of courses helpful to client care (Question S5a, S5b)

As with question S3, these questions were asked only of students who were interviewed in groups. For the purpose of counting the number of respondents who contributed to a view, we counted the group rather than the individual student. The number of students per group varied across the sites, from six in Site 1 to one in Sites 5 and 6.

Table 5.25 Views more important to mental health:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 1 MH 3 groups LD 0	Interpersonal and communication skills essential	Recognise the importance of interpersonal skills to practice	Interpersonal and communication skills training early on in nursing education is essential to good practice
V 2 MH 1 group LD 0	Nursing rather than medical models help to ensure that care is holistic and nothing is missed	Recognise the value to holistic care of nursing rather than medical models	Nursing models for ensuring holistic care are a priority
V 3 MH 1 group LD 0	Value of psychological theory to nurses and their understanding of clients within their different contexts	Develop open-mindedness from knowledge of psychological theory	Knowledge of psychology is important to the development of students into effective, holistic practitioners
V 4 MH 1 group LD 0	Value of sociological theory to nurses' understanding of inequality	Recognise the need to understand and relate inequalities to health	Knowledge of sociology for students to appreciate the inequalities of health and culture
V 5 MH 1 group LD 0	Value of role play to understanding body language	Willing to expose self during training to any discomforting consequences of role play	Videoed role play exercises are ideal for understanding interpersonal encounters and body language
V 6 MH 1 group LD 0	A&E experience prepares students in managing medical emergencies and associated emotional crises	Appreciate the educational value to students of A&E experience	A&E experience provides good training in managing medical and emotional emergencies
V 7 MH 1 group LD 0	General medical ward experience gives students an understanding of medical problems of people with mental illness	Recognise the value of general medical ward experience to mental health student training	General medical ward experience is important to the training of mental health nurses
V 8 MH 1 group LD 0	Experience on acute mental health wards gives students a range of learning opportunities not possible in community settings	Recognise the value of acute mental health wards to mental health student training even when practice is mainly community based	Acute mental health ward experience is essential for mental health students even when most practice is community based
V 9 MH 1 group LD 0	Depot clinics are a poor learning environment for students because of their 'production line' processes	Appreciate the kind of placements students need to learn	Keep students' experience in depot clinics to a minimum so that more time is available for experience in richer learning environments
V 10 MH 1 group LD 0	Experience in the voluntary sector exposes students to a social rather than medical model of care	Recognise the value of experience in the voluntary sector to students' learning	Experience in the voluntary sector exposes students to the social model of care rather than the medical model
V 11 MH 1 group LD 0	Learning about services and their mechanisms is valued by students		Shared learning to understand the range of services and the systems by which they work
V 12 MH 1 group LD 0	Working in a poor caring environment can be a good learning experience	Ensure students learn from working in poor caring environments	Bad wards can provide a good learning experience for students
V 13 MH 1 group LD 0	Value of counselling and therapy courses to practice	Recognise the value to students of counselling and therapy skills	Shared learning about counselling and therapies are beneficial to practice

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Table 5.26 Views more important to learning disability:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 14 MH 0 LD 2 groups	Value of courses on challenging behaviour to practice	Recognise students' needs for teaching about challenging behaviour	Training in managing challenging behaviour is a priority for practice
V 15 MH 0 LD 1 group	Importance of clinical supervision to good practice	Willing to act as a clinical supervisor to students and less experienced colleagues	Shared learning so that nurses can learn the principles and practice of clinical supervision from professions with more experience
V 16 MH 0 LD 1 group	Value of good care planning to the quality if the client's life	Appreciate the value of care plans for learning disability clients	Training in effective care planning a priority
V 17 MH 0 LD 1 group	Using the principles of normalisation and integration help to involve clients with their care	Recognise that the principles of normalisation help clients to participate in their care	Principles of normalisation and integration are a priority

APPENDIX 5A REQUIREMENTS FOR SKILLED PRACTICE FOR NURSING

A5A.1 MENTAL HEALTH

Table A5A.1 Mental Health Practitioners

SKILL CATEGORY/TYPE	**Frequencies**	
Management & Delivery of Care	**n**	**%**
1 Case management	12	6
2 Care programme approach	25	11
Assessment		
Planning		
Outcome evaluation		
Risk assessment (violence, self harm, relapse)		
Discharge planning & supervision registers		
3 Crisis intervention	11	5
4 Multidisciplinary work	16	7
5 Advocacy	1	0
6 Equal opportunities	2	1
7 Pharmacology & drug administration	1	0
8 Resource management	1	0
9 Quality assurance	1	0
10 Information technology	1	0
11 Clinical supervision	12	6
12 Working with statutory & voluntary services	6	3
13 Welfare rights skills	1	0
14 Management	9	4
15 Research awareness & implementation	5	2
16 Assessment of MH - when dual diagnosis	0	0
Sub Total	**104**	**48**

Table A5A.2 Mental Health Practitioners - continued

SKILL CATEGORY/TYPE	Frequencies	
Therapeutic skills	**n**	**%**
17 Ability to engage clients with long-term MI or challenging behaviour	27	12
18 Counselling skills/CBT	24	11
19 Bereavement counselling	2	1
20 Family work skills for people with learning disabilities	1	0
21 Therapeutic work with Dementia/supporting carers	3	1
22 Psychosocial interventions with schizophrenia/supporting carers & families	12	6
23 Groupwork skills	9	4
24 Life and social skills training	3	1
25 Behaviour modification techniques	0	0
26 Stress management	4	2
27 Assessment	6	3
28 Planning	3	1
29 Psychiatric liaison	1	0
30 Control & restraint	2	1
31 Drug administration and monitoring	4	2
32 User participation	4	2
33 Medical problems	1	0
34 Leisure management	0	0
35 Epilepsy management	0	0
36 Lifting/handling	0	0
37 MAKATON	0	0
38 Gentle teaching	0	0
39 Discharge management	0	0
40 MI because challenging behaviour	0	0
41 Working with sensory impairment	0	0
42 Physical care with multiple handicaps	0	0
43 Substance misuse	3	1
Sub Total	**109**	**50**

Table A5A.3 Mental Health Practitioners - continued

SKILL CATEGORY/TYPE	**Frequencies**	
Health Education and Health Promotion	**n**	**%**
44 Analysis of need	2	1
45 Health Education re: sexuality, marriage, parenthood	0	0
46 Promoting health e.g. healthy eating, exercise and monitoring medication	2	1
Sub Total	**4**	**2**

	n	**%**
Grand Total	**218**	**100**

A5A.2 LEARNING DISABILITY

Table A5A.4 Learning Disability Practitioners

SKILL CATEGORY/TYPE	Frequencies	
Management & Delivery of Care	**n**	**%**
1 Case management	4	2
2 Care programme approach Assessment Planning Outcome evaluation	14	7
Risk assessment (violence, self harm, relapse)		
· Discharge planning & supervision registers		
3 Crisis intervention	1	1
4 Multidisciplinary work	4	2
5 Advocacy	4	2
6 Equal opportunities	4	2
7 Pharmacology & drug administration	0	0
8 Resource management	5	3
9 Quality assurance	2	1
10 Information technology	0	0
11 Clinical supervision	7	4
12 Working with statutory & voluntary services	6	3
13 Welfare rights skills	2	1
14 Management	12	6
15 Research awareness & implementation	2	1
16 Assessment of MH - when dual diagnosis	1	1
Sub Total	**68**	**36**

Table A5A.5 Learning Disability Practitioners - continued

SKILL CATEGORY/TYPE	**Frequencies**	
Therapeutic skills	**n**	**%**
17 Ability to engage clients with long-term MI or challenging behaviour	22	12
18 Counselling skills/CBT	9	5
19 Bereavement counselling	0	0
20 Family work skills for people with learning disabilities	10	5
21 Therapeutic work with Dementia/supporting carers	0	0
22 Psychosocial interventions with schizophrenia/supporting carers & families	0	0
23 Groupwork skills	0	0
24 Life and social skills training	14	7
25 Behaviour modification techniques	10	5
26 Stress management	0	0
27 Assessment	14	7
28 Planning	13	7
29 Psychiatric liaison	0	0
30 Control & restraint	1	1
31 Drug administration and monitoring	1	1
32 User participation	8	4
33 Medical problems	2	1
34 Leisure management	2	1
35 Epilepsy management	2	1
36 Lifting/handling	1	1
37 MAKATON	3	2
38 Gentle teaching	1	1
39 Discharge management	1	1
40 MI because challenging behaviour	1	1
41 Working with sensory impairment	2	1
42 Physical care with multiple handicaps	2	1
43 Substance misuse	0	0
Sub Total	**119**	**62**

Table A5A.6 Learning Disability Practitioners - continued

SKILL CATEGORY/TYPE	**Frequencies**	
Health Education and Health Promotion	**n**	**%**
44 Analysis of need	0	0
45 Health Education re: sexuality, marriage, parenthood	4	2
46 Promoting health e.g. healthy eating, exercise and monitoring medication	0	0
Sub Total	**4**	**2**

	n	**%**
Grand Total	**191**	**100**

APPENDIX 6 QUESTIONS ON THE NHS & COMMUNITY CARE ACT

This chapter focuses on 19 questions asked which specifically refer to the provisions of the NHS & Community Care Act (1990). Respondents' views are summarised as described in the introduction to Appendix 5.

A6.1 Identification of unmet need in the community (Question W6.1, T3.2.1, C3.2.1, A4.1, D6.1 and S7.1)

Table 6.1 Views shared between mental health and learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 12 MH 12 (14) LD 7 (12)	Emphasis on needs based assessment	Ability to identify others' strengths and weaknesses	Needs based assessment and unmet need assessed at Level 2
V 9 MH 9 (10) LD 12 (20)	The NHS & CCAct and purchaser - provider split has led to greater awareness	Awareness of key issues	Requires education on community needs assessment
V 10 MH 8 (9) LD 6 (10)	Need to develop needs based assessment tools. Linking of social and health issues	Appreciation of social and health issues of community living	A module based on different types of assessment tools including needs based, social and health dominated
V 1 MH 8 (9) LD 5 (8)	Regular meetings with other professionals	Collaborative skills	Identification of unmet need through collaborative discussion

(in this and subsequent tables, MH - mental health, LD - learning disability)

View 12

This view was endorsed in all three MH sites: five Site 3, 3 Site 2 and 4 Site 1 respondents. It was expressed by managers/other professionals (7), workers (3), a lecturer and a user/carer.

For LD respondents, it attracted 3 responses from Site 5 and 3 from Site 6. It was primarily an issue for managers/other professionals (5).

View 9

This view was primarily an issue for respondents from the Site 1 (7) with one response from Site 2 and one from Site 3. It was identified by 5 managers/other professionals, 2 workers and 2 lecturers.

This was a prominent view for LD respondents, in particular for 8 from Site 4 and 3 from Site 5. There was a single response from Site 3. Six managers/other professionals and 4 workers and 2 lecturers identified it.

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View 10

This view was expressed in equal numbers by MH respondents from Site 1 (4) and Site 3 (4). Three managers/other professionals and 2 workers endorsed it.

For LD respondents this view was only an issue for Site 4 (4), and for managers/other professionals (4).

View 1

For MH this view was identified by Site 1 respondents (6) and 2 respondents from Site 3, most of whom were managers/other professionals (6).

For LD 3 respondents from Site 4 endorsed it, all of whom were managers/other professionals (3).

Table 6.2 Views more important to mental health:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 7 MH 15 (17) LD 1	Need to address problem of lack of resources	Sensitive and realistic communication	Resource implications and the problems of raising expectations
V 2 MH 9 (10) LD 3	Liaison with key community members	Good networking	Networking skills and liaising with community members on unmet need
V 4 MH 9 (10) LD 2	Target specific services for ethnic minority groups		Requires understanding of targeting strategy
V 13 MH 8 (9) LD 2	Ethno-sensitive services which address cultural differences	Culturally sensitive	What are ethno-sensitive services and how do they define and measure unmet need

View 7

For MH respondents this view was important to those in Site 1 (11), and Site 3 (3) with 1 from Site 4. It was identified by 6 managers/other professionals, 4 workers, 3 lecturers, 1 advocate and 1 student group.

View 2

This view was primarily identified by MH respondents from Site 1 (4) and Site 2 (4). It was an issue for managers/other professionals (5) and workers (2); it was identified by 1 lecturer and 1 advocate.

View 4

It was only an issue for respondents from Site 1 (9). Similarly, 7 managers/other professionals identified it with single responses from workers and lecturers.

View 13

This view was identified in all three MH sites: Site 1 (2), Site 2 (2) and Site 3 (4). It was mainly an issue for workers (5) and 3 managers/other professionals.

Table 6.3 ***Views more important to learning disability:***

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 5 MH 5 LD 9 (15)	No formal strategy of identification		How to develop tools for measuring unmet need in isolation
V 20 MH 5 LD 9 (15)	Access as well as availability of out of hours services. Taking the expressed needs of users on board	Identifying practical problems	Issues around access to resources and lobbying on basis of expressed needs
V 8 MH LD 5 (8)	Act as advocates to express dissatisfaction	Helping others to articulate	Advocacy and the nurse in terms of unmet need

View 5

This view mentioned in all the LD sites: Site 4 (4), Site 5 (3) and Site 6 (2). It was an issue for managers/other professionals (6) and workers (3).

View 20

For LD respondents this view was primarily identified by respondents from Site 4 (5) and Site 5 (3). There were 3 responses each from workers and lecturers, 2 from managers/other professionals and 1 from a student group.

View 8

This view was identified by respondents from Site 4 (2) and Site 5 (3), and mostly by managers/other professionals (4).

A6.2 Priority Client Groups (Question W6.2, T3.2.2, D6.2 and S7.2)

Table 6.4 ***Views shared between mental health and learning disability:***

View ID freq (%)	Service - Structure and Process	Practitioner - Personal Characteristics	Education - Aspects of Educational Provision
V 1 MH 18 (23) LD 7 (13)	Holistic, supportive and user-led nursing service. Nurses take lead on health and social assessment.	Prepared to take the lead in assessment.	Skills based curriculum oriented to user need.
V 9 MH 10 (13) LD 6 (11)	Holistic care which recognises the uses and misuses of diagnostic categories. Some treatments are effective, particularly with psychosis, whilst others are not.	Listening to users laterally and understanding aetiology, signs and symptoms of schizophrenia, manic depression etc.	A good academic grounding is needed to produce nurses who are knowledgeable and can challenge psychiatric assessment if necessary.

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View 1

This view was endorsed by respondents in Site 1 (13), with fewer in Site 3 (3) and Site 2 (2). For MH, relatively large numbers of workers (5) and managers/other professionals (12) identified this view, with one student group.

It was less important in the LD sites (7), being mentioned by 1 respondent from Site 4, 3 from Site 5 and 3 from Site 6. For LD 3 managers/other professionals, 2 workers, 1 lecturer and 1 student group identified it.

View 9

This was endorsed by MH respondents from Site 3 (5), Site 1 (3) and Site 2 (2), who were workers (4) and managers/other professionals (6).

Six LD respondents supported this view, spread equally across the three sites. Two were lecturers, 2 were managers/other professionals one was a worker and one a student group.

Table 6.5 Views more important to mental health:

View ID freq (%)	**Service - Structure and Process**	**Practitioner - Personal Characteristics**	**Education - Aspects of Educational Provision**
V 3 MH 14 (18) LD 1	Involvement of family and carers makes for effective rehabilitation. Equally, professional boundaries need to be maintained.	Honesty and openness in cross-agency referral.	Skills in monitoring users and involving other professionals. Setting limits in order to maximise resources.
V 6 MH 14 (18) LD 3	Priority groups need intensive support which can best be provided by specialist teams. Little is done for people with long-term conditions who are not psychotic.		Skills in working with long-term problems and providing long-term support focused on user need.
V 4 MH 8 (10) LD 1	Effective nurse networking, involving the voluntary and private sectors.	Employing innovative techniques to involve other agencies and sectors.	Learning the art of networking which might involve understanding how other sectors operate.
V 5 MH 8 (10) LD 3	Proactive working to enable users to cope with their own crises.	Taking risks in cooperation with users.	Training needed in risk assessment and management, safety and 'break-away' techniques for dealing with violence and coping with un-cooperative users.

View 3

This view was most often raised by MH respondents in Site 1 (9) and Site 3 (5). It was not expressed at all by respondents from Site 2. It was primarily an issue for workers (5) and managers/other professionals (7), with 1 lecturer and 1 student group.

View 6

This view was expressed by respondents from Site 1 (8), Site 3 (3) and Site 2 (3). There were 8 managers/other professionals a third of the lecturers (3 of 8) and 3 of 4 student groups.

View 4

Three respondents from Site 3, 4 from Site 1 and 1 from Site 2 identified this view. They were workers (3) and managers/other professionals (5)

View 5

Three MH respondents each from Site 1 and Site 3 identified this view and 2 from Site 2. Five of the respondents were managers/other professionals, with one worker, one lecturer and a student group.

Table 6.6 Views more important to learning disability:

View ID freq (%)	**Service - Structure and Process**	**Practitioner - Personal Characteristics**	**Education - Aspects of Educational Provision**
V 13 MH 2 LD 27 (50)	A service not confined to values based on behaviourism; offering user choice and control. A service to meet the needs of people with dual diagnoses.	Looking beyond challenging behaviour to understand its causes. Enhancing user empowerment by giving them choices and access, and helping those with additional physical impairments.	Shared learning for MH and LD students, though not in the CFP of P2K. Possibly some dual qualifications. A more generic approach with modules on challenging behaviour and user empowerment.

View 13

A large number of LD respondents from Site 4 (15) and Site 5 (9) supported this view together with 3 from Site 3. The strength of feeling for this view lay with managers/other professionals (13), workers (9) and lecturers (5).

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A6.3 Care/Case Management (Question W6.3, T3.2.3, C3.2.2, A4.2, D6.3 and S7.3)

Table 6.7 Views shared between mental health and learning disability:

View ID freq (%)	Service - Structure and Process	Practitioner - Personal Characteristics	Education - Aspects of Educational Provision
V 7 MH 25 (28) LD 6 (10)	Poor interface between purchasers and providers when control rests with social services. Should be focused in locality teams or budgeted through service brokers.	Being able to interface with another organisation that controls the finances for individual care.	An understanding of the differences between purchasers' and providers' functions.
V 9 MH 21 (24) LD 28 (49)	Practitioners to keep abreast of changing policy and legal requirements. Maintaining user involvement and participation.	Personal development in terms of changing policy and law.	An understanding of the priorities of social services and how to incorporate users' preferences.
V 4 MH 18 (20) LD (20)	Allocates responsibility to keyworkers ensuring continuity, accountability and evaluation.	Being more accountable to the individual. Focusing on the user.	Training in holistic assessment (levels 1 and 2) and evaluation.
V 2 MH 7 (8) LD 9 (15)	Vesting responsibility with social services not good for teamworking. Debate as to the benefits of nurse case managers offering hands-on care.	Determining an efficient balance between coordination and direct provision of care.	Management of resources and time.

View 7

This was a view shared across all three MH services: Site 1 (10), Site 3 (10) and Site 2 (5). It was raised by 14 managers/other professionals and 4 workers. Lecturers also saw this as a potential problem for care/case management (3) and also student groups (2) and one user/carer.

Although not such an issue for LD respondents, 6 did identify this view. There was an even spread across services: Site 4 (3), Site 5 (2) and Site 6 (1). Within respondent groups, 3 workers, 2 managers/other professionals and 1 user/carer identified it.

View 9

For MH, 7 Site 3, 5 Site 2, and 9 Site 1 respondents identified this view. A third were managers/other professionals (14), 3 (of 8)were lecturers, 3 were workers and one an advocate.

For LD, around half of the respondents from Site 4 (15) and Site 5 (10) endorsed this view. There were another 3 responses from Site 6. Managers/other professionals were vociferous (15) and also workers 8. Lecturers numbered 3 out of 9 whilst users/carers and student groups numbered 1 each.

View 4

As with View 9, the spread across MH services was fairly even: Site 1 (7), Site 3 (7) and Site 2 (4). Eight managers/other professionals, 4 lecturers, 3 workers, 2 users/carers and 1 student group raised it.

Amongst learning disability sector respondents, Site 4 and Site 5 provided 5 responses each and Site 6 2. Of these 12 respondents, 5 were managers/other professionals and there were 3 responses each from workers and lecturers. The remaining response came from an advocate.

View 2

Responses to this view were spread evenly across all three MH sites. Site 2 produced 3 responses and Site 1 and Site 3, 2 each. It was an issue for managers/other professionals (6). The only other response came from a lecturer.

Nine LD respondents raised this view, all from Site 4. Four were managers/other professionals, 3 were lecturers, one was a worker and one a user/carer.

Table 6.8 Views more important to mental health:

View ID freq (%)	**Service - Structure and Process**	**Practitioner - Personal Characteristics**	**Education - Aspects of Educational Provision**
V 1 MH 7 (8) LD 1	Multidisciplinary working with interchangeable nurses and social workers.	Ability to switch from a medical to social perspective.	Understanding of case management with a focus on keyworking.

View 1

This view was only identified by respondents from Site 1 and Site 3 (3 and 4 respectively). I attracted 4 responses from workers, 2 from users/carers and 1 student group. It was not an issue for LD respondents.

Table 6.9 *Views more important to learning disability:*

View ID freq (%)	Service - Structure and Process	Practitioner - Personal Characteristics	Education - Aspects of Educational Provision
V 6 MH 3 LD 11 (19)	Separate funding across authorities leads to poor cooperation. Should be client-led incorporating user - centred care plan.	Client-focused approach.	An understanding of the collaborative construction of client-centred care plans.
V 5 MH 6 (7) LD 6 (10)	Case management models lack coherence and require proactive nursing.	An ability to advocate and lobby on behalf of users.	Skills in budget holding and understanding of statutory powers.
V 12 MH 5) LD 5 (8)	Incorporate students in order to gain first hand experience.		Practical placements in a variety of settings. Social work students placed in hospitals.

View 6

Eleven LD respondents identified this view, mostly from Site 4 (5) and Site 5 (5). Nearly a quarter (6) of the managers/other professionals raised it and 3 workers. Two responses came from the 9 learning disability sector lecturers interviewed.

View 5

Responses to this view came from Site 4 (4) and Site 5 (2), 4 managers/other professionals and 2 lecturers.

View 12

Across sites, the response was 4 from Site 4 and 1 from Site 5. This view was identified by 3 managers/other professionals and 2 workers.

A6.4 Process and methods of user assessment (Question W6.4, T3.2.4, C3.2.3, A4.3, D6.4 and S7.4)

Table 6.10 Views shared between mental health and learning disability:

View ID freq (%)	Service - Structure and Process	Practitioner - Personal Characteristics	Education - Aspects of Educational Provision
V 13 MH 18 (20) LD 24 (41)	Application of more than one assessment tool. Assessing symptoms, setting goals, intervention and evaluation.	Ability to set goals and critique performance.	Learn a variety of techniques, including global or holistic.
V 5 MH 16 (18) LD 6 (10)	Client-led assessment. As much user involvement as possible. Meet need, don't merely assess problems.	An ability to encourage vulnerable people to participate.	Teach user-led assessment. Base assessment techniques around need.
V 17 MH 10 (11) LD 6 (10)	Better liaison between hospital and community on rehabilitation and long-term assessment.	Ability to be intuitive, not overly structured.	Rehabilitation as an ongoing process, hospital to community. Client-led assessment and shared action planning.
V 8 MH 9 (10) LD 6 (10)	Provide good practice opportunities and effective mentors.	When observing practice, an ability to reflect upon theory.	Some theoretical training in classroom, but best taught on placement through direct experience.
V 16 MH 9 (10) LD 11 (19)	Standardised assessment and joint purchasing/working to ensure best use of resources.	Ability to work collaboratively.	Standardised or joint assessment techniques, possibly through joint training. Effective multidisciplinary assessment.

View 13

This view was popular with MH respondents particularly those from Site 3 (10). There were 6 responses from Site 1 and 2 from Site 2. It was particularly popular amongst workers (8) and also managers/other professionals (8). The others were 2 out of 8 lecturers and a student group.

This view was also popular with LD respondents. Over half the Site 4 respondents identified it (15) and there were 5 responses from Site 5 and 4 from Site 6. Ten managers/other professionals, 6 workers, 4 lecturers all 3 student groups and 1 user/carer identified this view.

View 5

This view was raised by several MH respondents: there were 9 responses from Site 1, 4 from Site 2 and 3 from Site 3. Five workers and 6 managers/other professionals raised it. There were 2 responses each from lecturers and users/carers representing in both cases a quarter of those interviewed, and a single response was received from a student group. This view was not as important for LD respondents: 3 in Site 5, 2 in Site 4 and 1 in Site 6. This was an issue for only two groups, managers/other professionals (3) and workers (3).

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View 17

This view was important to some MH respondents: 5 from Site 3, 3 from Site 1 and 2 from Site 2. Users/carers (3), managers/other professionals (5), a worker and a lecturer endorsed it.

The view was important to a few LD respondents: 4 from Site 4 and 2 from Site 5. Three were managers/other professionals, 2 were workers and 1 a lecturer.

View 8

There were 3 responses from each MH site and 3 each from LD Sites 4 and Site 6 but none from LD Site 5.

For MH respondent types this was mainly an issue for workers (4) and managers/other professionals (4). For LD respondents there were 2 responses from the 9 lecturers interviewed, 2 from the 3 student groups, and one from a worker and a manager/other professional.

View 16

This view was relatively more important to LD than MH respondents although, in terms of numbers responding, they were similar. For MH it was raised mainly in Site 1 (6), with 2 responses from Site 3 and 1 from Site 2. For LD sites this was an issue for Site 5 (6) and Site 6 (3). Only 2 responses came from Site 4.

For MH respondent types across the MH services this view was endorsed by managers/other professionals (5), 2 lecturers, a worker and an advocate. For LD it was raised by managers/other professionals (5), lecturers (3) workers (2) and an advocate.

Table 6.11 Views more important to mental health:

View ID freq (%)	Service - Structure and Process	Practitioner - Personal Characteristics	Education - Aspects of Educational Provision
V 15 MH 12 (14) LD 2	Students poorly prepared for practical assessment or it is taught too broadly. Service needs to work with education.	A practical approach.	Education needs to cover assessment in much more depth, especially level 1 and 2. Teach standardised assessment and offer chance to observe in practice.
V 2 MH 10 (11) LD 3	Formal tools are used, though not standardised and sometimes applied flexibly.	Use of structured tools within a flexible approach.	Variety of tools available. Ability to apply in practice and develop own tools.
V 1 MH 9 (10) LD 3	Different tools may be used but in an informal way. Assessment locally is built up through professional judgement and use of expertise.	Ability to adapt formal tools to meet different circumstances.	How to adapt standard tools in practice. Flexibility and use of judgement.
V 3 MH 7 (8) LD 1	Prior knowledge of user for proper assessment. Issues around violence and safety also.	Being well prepared in advance.	Risk assessment and gaining prior information to aid assessment.
V 4 MH 7 (8) LD 1	Probing but non - confrontational. Relaxed style of questioning.	Good communicator able to make respondents feel relaxed.	Good communication skills. Probing and fact finding but in a style acceptable to the user.

View 15

This view was particularly popular with MH respondents from Site 3 (8). There were 3 responses from Site 2 and 1 from Site 1. Three responses each were received from managers/other professionals, lecturers and workers. Two of the 4 student groups also identified it.

View 2

This view was not often expressed although 5 Site 3 respondents identified it. Four responses came from Site 1 and 1 from Site 2. It was identified by workers (5) and managers/other professionals (5) only.

View 1

This view was identified by MH respondents particularly those in Site 1 (6). Two responses came from Site 3 and 1 from Site 2. It was an issue for managers/other professionals (5), workers (3) and a user/carer.

View 3

This view was identified by 4 Site 1 respondents, 2 from Site 2 and 1 from Site 3. Three workers, 2 lecturers and 2 managers/other professionals identified it.

View 4

This view was expressed mainly in Site 1 (5). Single responses came from Site 2 and Site 3. Three managers/other professionals, 2 workers, 1 user/carer and 1 student group identified it.

Table 6.12 ***Views more important to learning disability:***

View ID freq (%)	**Service - Structure and Process**	**Practitioner - Personal Characteristics**	**Education - Aspects of Educational Provision**
V 6 MH 3 LD 6 (10)	Therapeutic relationship and an ability to listen well. Use as an information giving process also.	Good listener.	Listening skills and information provision. Creation of a user history and provision of a relaxed atmosphere.
V 14 MH 3 LD 5 (8)	Nurses provide nursing assessment only but should apply level 1 psychological knowledge. Need for nurses to perform more complex techniques.	Observing psychological as well as physical issues.	More level 1 to be taught. Also social as well as physical needs.

View 6

This view was expressed by LD respondents: 3 from Site 5, 2 from Site 6 and 1 from Site 4. It was primarily an issue for workers (5) with 1 response from a user/carer.

View 14

This view was important to a few LD respondents: 3 from Site 5 and 2 from Site 4. All were managers/other professionals (5).

A6.5 Community discharge plans (care programme approach) (Question W6.5, T3.2.5, C3.2.4, A4.4, D6.5 and S7.5)

Table 6.13 ***Views shared between mental health and learning disability:***

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 3 MH 18 (20) LD 5 (8)	Part of nursing process with nurse involvement from admission to discharge and beyond	Ability to consider the whole of an individual's community needs on discharge	Requires knowledge of all the services available
V 2 MH 17 (19) LD 5 (8)	Requires structured assessment, action planning and good team working	Negotiation skills and the ability to take a wider view	Assessment and goal setting. A multi-agency approach with shared learning in social issues

View 3

This view was important in all 3 MH sites: Site 1 produced 6 responses, Site 3 (7) and Site 2 (5). It was an important view for managers/other professionals (8) and workers (6). There were 3 responses from users/carers and 1 from a lecturer.

Though less of an issue for LD respondents this view was identified by 3 from Site 4 and 2 from Site 5. It was raised mostly by managers/other professionals (3).

View 2

For MH this view was raised by respondents from Site 1 (9) and from Site 3 (5). Three responses came from Site 2. Nine managers/other professionals, 6 workers, 2 student groups and 1 lecturer identified it.

For LD respondents, this view was most prominent in Site 4 (4). Three managers/other professionals and 1 worker and 1 lecturer identified it.

Table 6.14 Views more important to mental health:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 4 MH 21 (24) LD 4 (7)	Need for continuity between and across hospital and community team carers. Works best with care/case management	Thinking flexibly about hospital and community provision	Examine relationship between doctors, nurses and careworkers' assessments
V 1 MH 14 (16) LD 3	Good communication and record keeping. Good networking and liaison	Good communication skills and strategies to cope with non-compliance	Skills in communicating across services and care sectors. Maintaining continuous records
V 7 MH 10 (11) LD 1	Assertiveness and advocacy to challenge inappropriate discharge plans	Need to be outgoing, confident and able to involve others	Skills in verbal and written presentation. Training in assertiveness
V 5 MH 9 (10) LD 1	Clients require aftercare packages with community carer involvement prior to discharge	Ability to understand and disseminate complicated legal requirements	Awareness of Mental Health Act, NHS & Community Care Act and other legislative requirements.
V 6 MH 9 (10) LD 0	Rights and views of user essential in discharge process	Showing concern for users' rights, views and wants	Understanding users' rights in discharge. How to give more involvement, information and empowerment
V 9 MH 9 (10) LD 4	Wide range of student placements covering acute rehabilitation and elderly	Applying principles to practice	Knowledge acquired in the classroom is critically evaluated in practice

View 4

This view was raised by MH respondents in Site 1 (13), Site 2 (5) and Site 3 (3). Eleven workers, 3 users/carers, 2 lecturers and an advocate raised it.

View 1

This view was mainly identified by MH respondents from Site 1 (9) and Site 3 (4). It was primarily an issue for workers (7) and managers/other professionals (5). Single responses came from a lecturer and a student group.

View 7

MH respondents were 4 in Site 3, 4 in Site 1 and 2 in Site 2. Six managers/other professionals, 3 workers and 2 lecturers identified it

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View 5

This view was more important to respondents from Site 3 (5) than Sites 1 and 2 (2 each). It was raised mostly by workers (4) and managers/other professionals (4) .

View 6

This view was more of an issue for Site 1 (4) and Site 3 (4) respondents, with the main interest coming from workers (5). There were 2 responses each from advocates and managers/other professionals and 1 response from a user/carer.

View 9

This view was important to respondents from Site 3 (5) and Site 1 (4). Five managers/other professionals, 3 workers and a lecturer identified it.

A6.6 Implications for people from different cultural backgrounds (Question W6.6, T3.2.6, C3.2.5, A4.5, D6.6 and S7.6)

Table 6.15 Views shared between mental health and learning disability:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 1 MH 36 (41) LD 19 (32)	Treat people from different cultures as individuals not groups	Not labelling people	Understanding cultural and ethnic similarities and differences within and between ethnic groups and the meaning of mental illness and LD within different cultures
V 3 MH 33 (38) LD 11 (19)	Need for more ethnic workers	Ability to speak other languages	Requires recruitment policies to target black and Asian groups and challenge stereotypes of nursing held by them. Language electives advisable in pre- and post-reg education
V 2 MH 14 (16) LD 15 (25)	A working knowledge of culture in terms of practical daily living	Ability to empathise with cultural living differences	Basic understanding of how culture affects social and working lives
V 6 MH 7 (8) LD 7 (12)	Danger of discriminatory and/or oppressive practice to ethnic minority users	Vigilance against any forms of discrimination	Racial awareness training like that received by social workers

View 1

For MH, almost half (22) Site 1 respondents identified this view along with 8 from Site 3 and 6 from Site 2. It was endorsed by managers/other professionals (24), workers (6) and lecturers (3). One response came from a user/carer, an advocate and a student group.

This view was equally important to LD respondents: 10 from Site 4, 7 from Site 5 and 2 from Site 6. It was important to managers/other professionals (10), lecturers (4), 3 workers, 1 user/carer and 1 advocate.

View 3

This view was particularly relevant to MH respondents from Site 1 (22). Seven responses came from Site 3 and 4 from Site 2. All respondent groups endorsed it: 15 managers/other professionals, 8 workers, 4 of the 8 lecturers, 3 users/carers 2 student groups and 1 advocate.

The LD respondents who endorsed this view were from Site 4 (6) and Site 5 (4). It was an issue for managers/other professionals (5), workers (3), and 2 of the 4 users/carers.

View 2

All three MH sites responded to this view; 6 from Site 1, 4 from Site 2 and 4 from Site 3. It was mainly an issue for managers/other professionals (7), and lecturers (3), with 2 responses each from workers and users/carers.

This view was mainly identified by Site 4 (7) and Site 5 (6) LD respondents. It was primarily an issue for managers/other professionals (7) and workers (5). Single responses came from a lecturer, and advocate and a student group.

View 6

In MH 3 responses each were received from Site 1 and Site 2. All the student groups interviewed and a quarter of the lecturers, endorsed it.

In LD, it was primarily an issue for Site 5 (5). Three workers and 2 managers/other professionals identified it and there were responses from a lecturer and a student group.

Table 6.16 Views more important to mental health:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 5 MH 8 (9) LD 1	Culturally sensitive and accessible services	Friendly, non-threatening and sensitive approach	How to make people from different cultural backgrounds comfortable with the main stream services

View 5

This view was important for some respondents from Site 1 (7). It was an issue particularly for managers/other professionals (6), with a worker and a student group.

A6.7 Domiciliary, day care and respite services

Table 6.17 ***Views shared between mental health and learning disability:***

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 2 MH 16 (18) LD 14 (24)	Proactive resourcefulness to make best use of the service infrastructure for the benefit of users	Proactive initiators rather than reactive copers	Shared learning so that all professionals have knowledge of the services available and how to network effectively
V 8 MH 10 (11) LD 9 (18)	Flexible user-led services that acknowledge the risk-benefit balance necessary for ordinary living	Become responsive to a user-led approach and accept that a level of risk is necessary for wellbeing	Shared learning increases knowledge and promotes flexibility and open-minded attitudes to a user-led service
V 6 MH 6 (7) LD 9 (15)	Day care should be more flexible, imaginative, integrated into the community and involve users in care planning	Become lateral thinkers so seeing possibilities beyond the stereotyped service	Shared learning would expose nursing students to the techniques and inventiveness that other professionals use to achieve the best services for their users

View 2

This view was important to MH respondents from Site 3 (8), Site 1 (6) and Site 2 (2). It was identified mostly by workers (6) and managers/other professionals (8). Two responses were received from lecturers.

For LD respondents this view was primarily an issue for Site 4 respondents (11). Two responses came from Site 5 and 1 from Site 6. It was most important to managers/other professionals (7) and workers (5). The remaining 2 responses were from lecturers.

View 8

This view was of some interest to MH respondents with 3 responses from Site 2 site, 5 from Site 1 and 2 from Site 3. In terms of respondent types there were 4 responses each from workers and managers/other professionals. The remaining 2 responses came from a lecturer and a user/carer.

This view was relatively more important to LD respondents where 3 of those from Site 6 and 5 from Site 4 raised it. Four managers/other professionals, 2 workers, 2 lecturers and 1 user/carer endorsed it.

View 6

This view was supported by some MH respondents: 4 from Site 1 and 2 from Site 3. Four managers/other professionals, a worker and a user/carer identified it.

This view was relatively more important to LD respondents: 6 from Site 5, and 3 from Site 4. Across respondent types 4 workers, 3 managers/other professionals a lecturer and a user/carer identified it.

Table 6.18 Views more important to mental health:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 1 MH 5 LD 0	Many services going into people's homes can be intrusive particularly if workers disapprove of the way people live	Awareness that the way users live is no concern to the nurse unless there are implications for a user's health	Shared learning and multi-skilling might reduce the number of workers who visit users at home and might prevent nurses from becoming judgmental with users at home
V 5 MH 5 LD 1	Training needed for home helps on mental health issues	Appreciate the importance of training home helps in basic mental health care	Preparing nurses to train and supervise domiciliary care workers is a priority

View 1

This view was identified by 3 Site 1 and 2 Site 3 respondents, of whom 3 were managers/other professionals, 1 was a worker and 1 a lecturer.

View 5

As with the previous view this view was identified by 3 Site 1 and 2 Site 3 respondents. The array of responses across respondent types was the same as *View 1*.

Table 6.19 Views more important to learning disability:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 9 MH 0 LD 5 (8)	Successful coordination between the user, the family, all carers and the principal service	Appreciate the need to be effective coordinators for users from different background and with different needs	Shared learning of communication and coordination skills so that the diverse needs of users from different background are acknowledged

View 9

This view was identified by Site 4 (3) and Site 6 (2) respondents. It was mainly an issue for managers/other professionals (4) .

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A6.8 Collaboration between professionals (Question W6.8, T3.2.8, C3.2.7, A4.7, D6.8 and S7.8)

Table 6.20 Views shared between mental health and learning disability:

View ID freq (%)	Service - Structure and Process	Practitioner - Personal Characteristics	Education - Aspects of Educational Provision
V 1 MH 34 (39) LD 28 (47)	Maintain nurse identity whilst setting common goals in an environment of joint working.	Able to work collaboratively whilst maintaining individuality.	Skills in working with other professionals whilst maintaining own identity.
V 4 MH 21 (24) LD 22 (37)	Breaking down separate identities in a multidisciplinary setting.	Applying a generic approach to care.	Joint training and dual qualifications. Social as well as medical aspects of care.
V 3 MH 12 (14) LD 13 (22)	Single management structure.	Flexible approach to supervision and support.	Joint training and an understanding of the perspectives of other professionals

View 1

This view was raised by most Site 2 respondents (11), followed by Site 3 (10) and Site 1 (13). Nearly half the workers (11) and managers/other professionals (17) identified it. User(s) who saw this role separation as important numbered 3 (of 8) and lecturers and student groups numbered 2 and 1 respectively.

This view was also raised by a relatively large proportion of LD respondents (28): 15 from Site 4, 10 from Site 5 and 3 (of 11) from Site 6. Thirteen managers/other professionals, 8 workers, half of the 9 lecturers, 2 users/carers and 1 advocate endorsed it.

View 4

Of the MH sites, 9 Site 1, 8 Site 3, and 4 (of 18) Site 2 respondents identified this view. Across respondent groups, 10 managers/other professionals, half of the 8 lecturers, 4 workers, 2 student groups and 1 user/carer endorsed it.

This view was relatively more important to LD respondents: 10 from Site 4, 8 from Site 5 and 4 (of 11) from Site 6. In terms of respondent groups, 12 managers/other professionals, 5 (of 9) lecturers, 4 workers and 1 student group endorsed it.

View 3

This view was mainly an issue for MH respondents from Site 1 (7) and Site 3 (4). Only 1 respondent from Site 2 expressed this view. Regarding respondent groups, 9 managers/other professionals, 2 lecturers and 1 worker identified it.

Similarly for LD respondents in Site 4 (8) and Site 5 (4) identified this view, whilst Site 6 produced only 1 response. Six (of 26) managers/other professionals, 2 workers, 2 lecturers, 2 users/carers and 1 advocate raised it.

Table 6.21 *Views more important to mental health:*

View ID freq (%)	Service - Structure and Process	Practitioner - Personal Characteristics	Education - Aspects of Educational Provision
V 2 MH 11 (13) LD 3	Networking with other services and contact points.	Good interpersonal and negotiation skills.	An understanding of how to network fully in the community.

View 2

This view was primarily expressed in Site 1 (9), with 2 responses coming from Site 3, mostly by managers/other professionals (7) and workers (3). One response came from a lecturer. It was not a major issue for LD respondents.

A6.9 Management of support workers (Question W6.9, T3.2.9, D6.9 and S7.9)

Table 6.22 *Views shared between mental health and learning disability:*

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 2 MH 26 (34) LD 14 (26)	Nurses performing a managerial role with support staff	Assertive and supportive	Management skills, training and supervisory skills. May be more appropriate at placement level or gained in practice
V 7 MH 22 (29) LD 11 (20)	Provide peer support and training as well as encouraging external training. Good induction for support workers	Good explanation and communication. Ability to put people at ease	Trained trainers. Skills in providing support as well as supervision
V 11 MH 18 (23) LD 19 (35)	Good induction and ongoing training. External training, especially NVQs	Clear and articulate	Trained trainers, with particular reference to stress/vulnerability, CPA and The NHS & CCAct
V 1 MH 14 (18) LD 9 (17)	Accepting support workers' practical and relationship-building worth	Adopting a less structured more creative approach	Recognition of support workers in terms of practical skills, closer rapport with users and more flexible style
V 13 MH 9 (12) LD 19 (35)	Motivate and develop staff through supervision and employ skills in counselling and risk assessment	Able to motivate others	ENB 998 less nurse focused. Concentrate on development of practical skills
V 12 MH 8 (10) LD 6 (11)	Greater team approach with the inclusion of support workers	Encourage all team members to make a contribution	Skills in team working and team case reviews. Ability to lead but also elicit views from others

View 2

Although an important view in all three MH sites, it was of particular relevance to respondents from Site 3 (13). Site 2 respondents numbered 5 whilst 8 responses were

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received from Site 1. This view was an issue mainly for workers (11) and managers/other professionals (14).

Within the LD services this view was more popular in Site 4 (11) than the others. It was endorsed by 6 managers/other professionals, 3 lecturers and 4 workers.

View 7
This view was equally important to respondents in Site 1 (13) and Site 3 (7). Two responses were received from Site 2. Twelve managers/other professionals, 6. Half the lecturers interviewed expressed this view.

For LD this view was primarily an issue for Site 4 (7). Three responses came from Site 5 and 1 from Site 6. This was an issue for workers (7) and lecturers (3) in the main.

View 11
This view was expressed by 8 MH respondents in Site 1 and 8 in Site 3. Two responses came from Site 2. This was more of an issue for managers/other professionals (13) but was also identified by 3 workers, a lecturer and a student group.

This was an important issue for all three LD services: 8 respondents from Site 4, 7 from Site 5 and 4 from Site 6. As with the MH services this view had greater relevance for managers/other professionals (12) but was also identified by 4 workers and a third of the lecturers.

View 1
Across the MH services this view was expressed by 9 respondents from Site 1, 4 from Site 3 and 1 from Site 2. It was primarily an issue for managers/other professionals (9) and workers (3) with 2 responses from the 8 lecturers interviewed.

Across LD services this view was expressed by 3 respondents from Site 4, 5 from Site 5 and 1 from Site 6. It was an issue for managers/other professionals (5) and workers (2) with 1 response each from a lecturer and a student group.

View 13
The MH respondents who raised this view came from Site 1 (4) and Site 2 (4). Five managers/other professionals and 3 (of 8) lecturers expressed it.

This view was relatively more popular amongst LD respondents: 12 from Site 4, 3 from Site 6 and 4 from Site 5. It was mainly an issue for managers/other professionals (13) and lecturers (4 of 9), with a worker and a student group.

View 17

This view was not often expressed by either type of service. Nevertheless, 6 respondents from Site 3 and 4 from Site 5 endorsed it. Across respondent groups, 3 managers/other professionals and 3 workers from the MH sites expressed this view whilst 4 managers/other professionals and 2 workers did so from the LD sites.

Table 6.23 Views more important to mental health:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 3 MH 12 (16) LD 2	Greater role clarification with support workers having restricted responsibilities	Good communication and sensitive limit setting	Skills in boundary setting and clarity of task
V 4 MH 7 (9) LD 4 (7)	Greater nurse understanding of skills of NVQ qualified workers. Closer links with NVQ	Able to assess and mentor for others	Knowledge of NVQ training. Acting as supervisor, mentor, lecturer and assessor

View 3

Equal numbers of respondents expressed this view across the MH services. Four each from Site 1, Site 3 and Site 2. Five managers/other professionals and 5 workers identified this view along with 2 lecturers.

View 4

This view was an issue for some respondents from Site 1 (5). Single responses came from Site 2 and Site 3. Two 2 responses each came from lecturers, workers and managers/other professionals, and one from a student group.

A6.10 Support for carers and consultation with users and carers (Question W6.9, T3.2.9, D6.9 and S6.9)

Table 6.24 Views shared between mental health and learning disability:

View ID freq (%)	Service - Structure and Process	Practitioner - Personal Characteristics	Education - Aspects of Educational Provision
V 2 MH 30 (34) LD 19 (32)	Support for carers in a family or group environment. Giving information to carers about aetiology and treatment.	Empathy for carers and families.	How to support families and give them more information. Group and family work, not confined to social services. More family placements.
V 7 MH 25 (28) LD 20 (34)	Consulting carers and users whilst also maintaining a clinical intervention role	Communication and empathy.	Empowerment and consultation whilst caring and organising care. Understanding the system of care and the language of the user.
V 6 MH 15 (17) LD 10 (17)	Encourage participation through user groups.	How to include people and create the right atmosphere.	User consultation and an emphasis on group work and group dynamics.
V 9 MH 9 (10) LD 7 (12)	Giving opportunity for users and user groups to criticise.	Being able to accept criticism.	Involving users and user-oriented groups in education. Allow them to express their views.
V 10 MH 8 (9) LD 8 (14)	Psychosocial intervention with families, involving counselling and anxiety/stress management.	Tact and diplomacy. Communication and approachability.	Training in counselling in a psychosocial mode. Stress/anxiety management, family therapy, group dynamics etc.

View 2:

This view was important to many of the MH respondents: Site 3 (11), Site 2 (9), and Site 1 (10). It was particularly popular with managers/other professionals (19) and lecturers (4). Three users/carers, 4 workers and an advocate addressed this issue.

This view was also identified by many LD respondents: Site 6 (5), Site 5 (7), and Site 4 (7). In terms of respondent groups it was important to managers/other professionals (10) and 4 workers, 3 lecturers and 2 users/carers.

View 7

This view was highlighted by both MH and LD respondents. In the MH sites it was raised by 14 Site 1, 8 Site 3 and 3 Site 2 respondents. I was primarily an issue for managers/other professionals (17) and workers (7).

In LD sites this view was also important: it was endorsed by 9 Site 4, 7 Site 5 and 4 Site 6 respondents. In terms of respondent types, 8 managers/other professionals, 5 (of 9) lecturers, 4 workers, 2 (of 4) users/carers and 1 advocate identified it.

View 6

This view was endorsed by MH respondents in Site 3 (5), Site 1 (8), and Site 2 (2 respondents). They were workers (6), 2 lecturers, 5 managers/other professionals and a user/carer.

For LD respondents there were 4 responses each from Site 4 and Site 5 , with 2 responses from Site 6. There were 4 managers/other professionals, 2 workers and a lecturer, a user, an advocate and a student group.

View 9

This view was mainly an issue in the MH services for respondents from Site 3 (5). Two responses came from Site 1 and 1 from Site 2. It was raised by 3 workers, 2 lecturers and 3 managers/other professionals.

Across LD sites this view was primarily an issue for those from Site 4 (6), with 1 Site 5 and 1 Site 6 respondent. Most were managers/other professionals (4) with workers (2), a lecturer and a student group.

View 10

This view was expressed by some MH and LD respondents. For MH: 5 were from Site 1, 2 from Site 2, and 2 from Site 3. It was an issue for lecturers (3 of 8), managers/other professionals (4), a worker and a student group.

For LD this view was more of an issue for Site 5 (4) than Site 4 (2) and Site 3 (1). It was important to workers (3), managers/other professionals (2), a lecturer and a student group.

A6.11 Good access to services (advocacy, brokerage, user's rights and user involvement) (Question W6.11, T3.2.11, C3.2.9, A4.9, D6.11 and S7.11)

Table 6.25 Views shared between mental health and learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 6 MH 20 (23) LD 14 (16)	Need for more independent advocacy. Nurses cannot be effective advocates but should seek it as a service for their users	Advocating to certain limits and understanding when outside intervention is needed	Understanding the role of advocates, brokers and interpreters
V 3 MH 15 (17) LD 8 (14)	Debate on how much nurses can act as independent advocates.	Developing the art of enabling others to fend for themselves	Learning about the role of advocacy and debating its likely practical application
V 1 MH 14 (16) LD 10 (17)	Informing users of their rights and giving them greater empowerment	Being supporters rather than providers	Skills in empowerment issues such as self-medication. Knowledge of users' rights
V 7 MH 7 (8) LD 5 (8)	Immediate assessment is needed for rapid referral to appropriate professional(s)	Knowing when it is appropriate to refer users onto other professionals	Requires knowledge of the range of services available and professional role boundaries

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View 6

For MH, this view was identified by 12 Site 1 respondents, and 4 each from Site 3 and Site 2. It was important to users/carers (5) and a smaller proportion of managers/other professionals (10) and workers (3).

This was also an important issue for LD respondents in two of the three sites: 10 from Site 4 and 4 from Site 5. It was identified by 7 managers/other professionals, 4 workers, 2 (of 9) lecturers and 1 student group.

View 3

It was primarily an issue for MH respondents from Site 1 (7) and Site 3 (7). Half the 8 lecturers, 6 managers/other professionals, 4 workers and 1 student group identified this view.

For LD this view was most important to respondents from Site 4 (6), and by 4 managers/other professionals, 3 workers, and 1 user/carer.

View 1

This view was mainly an issue for respondents from Site 1 (12), with 2 MH responses from Site 3. Five workers and 5 managers/other professionals, 2 users/carers, a lecturer and a student group expressed this view.

For LD respondents this view was an issue for Site 5 (6) and Site 4 (4). They were managers/other professionals (6), 2 lecturers, 1 worker and 1 user/carer.

View 7

This view was identified by MH and LD respondents: 4 from Site 1 and 2 from Site 3; and 2 each from Site 5 and Site 6 and 1 from Site 4.

Three were managers/other professionals, 2 were lecturers and 2 were users/carers from the MH sites. For the LD sites this issue was identified only by managers/other professionals (5).

Table 6.26 Views more important to mental health:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 4 MH 7 (8) LD 4 (7)	Greater user participation even to the extent of challenging care and drug regimes	Helping someone to overcome their vulnerability and be more assertive	How to empower users to let them exercise such power

View 4

This view was mainly an issue for respondents from Site 1 (5). Single responses came from Site 3 and Site 2. Four of respondents were managers/other professionals and 2 were workers.

Table 6.27 Views more important to learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 8 MH 4 LD 7 (12)	Networking and negotiating for users with other professionals	Communication, negotiation and networking abilities	Skills in different forms of communication and how to both empower users and lobby on their behalf

View 8

This view was primarily identified by respondents from Site 5 (4). There were 2 responses from Site 4 and 1 from Site 6. A third of all LD lecturers interviewed endorsed this view together with 3 managers/other professionals, and a worker.

A6.12 Provision of information for users and carers (Question W6.12, T3.2.12, C3.2.10, A4.10, D6.12, S7.12)

Table 6.28 Views shared between mental health and learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 2 MH 30 (34) LD 24 (41)	Information giving locally is good	Understanding the importance of giving information	Knowing how to provide good information and sell/market the service
V 6 MH 23 (26) LD 19 (32)	Delivery and communication	Good communication skills	A practical approach to information giving. Forms of delivery and communication
V 8 MH 8 (9) LD 5 (8)	Involve users in the types of format required	Appreciate the importance of working with users	How to engage users in planning and provision

View 2

This view was identified by all three MH sites: 12 from Site 1, 10 from Site 3 and 8 from Site 2. Half the lecturers, 15 managers/other professionals, 8 workers and 3 users/carers endorsed it.

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This view was also important to LD respondents in all three sites: 15 from Site 4, 4 from Site 6 and 5 from Site 5. Ten were managers/other professionals, 8 were workers, 4 (of 9) were lecturers, a user/carer and a student group.

View 6

This view was primarily an issue for two of the MH sites: 14 Site 1 and 8 Site 3 respondents. In terms of respondent type 14 managers/other professionals, 5 workers and 3 (of 8) lecturers endorsed it.

This was also a prominent issue for some LD respondents: 11 came from Site 4, 7 from Site 5 but only 1 from Site 6. Most of the lecturers interviewed (6) raised it; also 7 managers/other professionals, 5 workers and 1 advocate.

View 8

For MH there were 4 responses from Site 3 and 2 responses each from Site 1 and Site 2. In the LD services this view was really only an issue for Site 5 (3), with one single response each from Site 4 and Site 6.

This view was raised by 4 MH managers/other professionals, 2 workers, 1 lecturer and 1 user/carer. Within the LD services 2 managers/other professionals, 2 lecturers and 1 worker also expressed this view.

Table 6.29 Views more important to mental health:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 12 MH 21 (24) LD 4 (7)	Services locally are poor	Sensitivity on issues of appropriate information giving	What information can and should be given on illness and condition
V 11 MH 13 (15) LD 2	Information on condition and treatments	Understanding the need for users/carers to get information on illnesses as well as services	Training in breaking bad news
V 5 MH 11 (13) LD 4 (7)	Existence of a complaints procedure	Sensitivity in dealing with user/carer complaints	Different forms of complaints systems and how to make users aware of their rights.
V 13 MH 8 (9) LD 2	Confidential record keeping and tact in information giving	Tact and confidentiality	Training in entering record recording sensitive information
V 15 MH 7 (8) LD 2	Understanding the role of those organisations included in the information process	Good networking skills	Networking with other organisations and having an overview of welfare issues, housing, local politics and the law

View 12

This view was particularly important to MH respondents from Site 1 (14). A further 4 responses came from Site 3 and 3 from Site 2. Half the users/carers interviewed (4) identified this view as did 13 managers/other professionals and 4 workers.

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View 11

This view was really only an issue for respondents from Site 1 (8) and Site 3 (4). Eight managers/other professionals, 2 workers and 2 users/carers endorsed it.

View 5

It was of interest mainly to respondents from Site 1 (8). Two responses were received from Site 3 and 1 from Site 2. They were managers/other professionals (9), and a worker and a lecturer.

View 13

This view which was endorsed in Site 1 (5) and Site 3 (3). It was primarily an issue for managers/other professionals (6) .

View 15

As with *View 13* this was an issue primarily for Site 1 and Site 3, with 3 responses from each . Again, this was mainly and issue for managers/other professionals (6) .

Table 6.30 Views more important to learning disability:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 16 MH 2 LD 5 (8)	Incorporating the use of computers to design information format	IT awareness	Skills in using computers and desk-top publishing

View 16

Most responses came from Site 4 (4), from managers/other professionals (3) and lecturers (2).

A6.13 Multidisciplinary training (Question W6.13, T3.2.13, D6.13 and S7.13)

Table 6.31 Views shared between mental health and learning disability:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 1 MH 22 (29) LD 8 (15)	Beneficial to both service providers and users	Empathy with other professions	Best taught jointly with social workers at post-basic level or on placement
V 2 MH 19 (25) LD 17 (31)	Respondents benefited in practice	Positive about joint provision	Experience of good practice
V 7 MH 9 (12) LD 5 (9)	Good for team building and policy consistency	Positive team member	Team building, policy coordination, working with peripheral carers and understanding inplications of nurse action
V 5 MH 7 (9) LD 7 (13)	Nurse maintains separate identity	Ability to work with other but maintain professional boundaries	Multidisciplinary training but not to produce generic carers
V 9 MH 6 (8) LD 17 (31)	Multidisciplinary training at all levels	Exclusivity avoidance	Shared learning to create generic workers

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View 1

This view was particularly popular amongst MH respondents within Site 1 (11) and Site 3 (10). Eleven managers/other professionals, 6 workers, 4 (out of 8) lecturers and 1 student group identified it

Although less important to LD respondents, Site 4 produced 4 and Site 5 produced 4 responses. There were 6 responses from managers/other professionals and 2 from lecturers.

View 2

Across MH services this view was identified in all three sites: 8 respondents from Site 1, 6 from Site 3 and 5 from Site 2. Thirteen managers/other professionals and 6 workers endorsed it.

This view was also important to LD respondents: Site 5 (10), Site 4 (4) and Site 6 (3). Ten managers/other professionals, 3 workers, 2 lecturers, and 2 student groups identified it.

View 7

The MH response rate was 4 from Site 1, 3 from Site 2 and 2 from Site 3. Eight of the 9 responses received came from managers/other professionals.

For the LD respondents: 2 each came from Site 4 and Site 6 and 1 from Site 5. Three of the 9 lecturers and 2 managers/other professionals endorsed it.

View 5

This view was expressed by some respondents from both MH and LD (7 in each case). For MH 4 came from Site 3, 2 from Site 2 and 1 from Site 1. For LD, 5 came from Site 4 and 2 responses from Site 5.

Four workers , 2 managers/other professionals, a lecturer and a student group from the MH services expressed this view. LD respondents were 4 lecturers, 2 managers/other professionals and 1 worker.

View 9

With regards to the MH services 3 responses came from Site 1 and 2 from Site 3. Five of the 6 responses received were from managers/other professionals.

This view was far more important to LD respondents, particularly for Site 5 (9) and Site 4 (7). It was raised by 10 managers/other professionals, 3 workers and 4 (of 9) lecturers.

Table 6.32 Views more important to mental health:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 4 MH 12 (16) LD 2	No multidisciplinary training locally	Retains nursing identity	Joint training not advocated

View 4

It was endorsed mainly by respondents from Site 1 (9), with 2 responses from Site 3 and 1 from Site 2. In terms of respondent type, 6 managers/other professionals and 5 workers expressed this view.

A6.14 Involvement of the private and voluntary sector (Question W6.14, T3.2.14, D6.14 and S7.14)

Table 6.33 Views more important to mental health:

View ID freq (%)	Service - Structure and Process	Practitioner - Personal Characteristics	Education - Aspects of Educational Provision
V 2 MH 15 (19) LD 0	Nurses need to know what's available locally and access this for their users.	Good networking skills.	Learning about how to research local activity and network good contacts for improved user choice.
V 5 MH 9 (12) LD 3	These organisations have access to funds not available to the NHS. They need to be included in larger-scale care planning.	Willingness to consult and take advice.	Understanding of unique funding implications.
V 4 MH 8 (10) LD 0	MIND and MENCAP are the major voluntary sector players. Nurses need more knowledge of these.	Good networking skills	Understanding of the organisation and aims of MIND and MENCAP in particular.
V 1 MH 6 (8) LD 0	Lack of appreciation from nurses. Need to understand their role better and provide support.	Taking a wider view in terms of all types of community carers.	Learning about the organisation and ethos of voluntary and private agencies. More placements needed. Need to support other sectors.
V 11 MH 6 (8) LD 0	Nurses must play a role in monitoring the quality of provision.	Sensitivity when overseeing the performance of other organisations.	An understanding of contractual obligations and the profit motive. How to apply quality and standards to these groups.

View 2

This view was important only to MH respondents from Site 1 (15). It was an issue for managers/other professionals (9), workers (3), 2 of the 4 student groups and 1 lecturer.

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View 5

Like *View 2* this one was most important to respondents from Site 1 (8). Four managers/other professionals, 3 workers, a lecturer and a student group raised it.

View 4

As before this view was identified only by respondents from Site 1 (8), and mainly by managers/other professionals (7).

View 1

Again, this view was identified by Site 1 respondents only (6). It was an issue for managers/other professionals (4), a lecturer and a worker.

View 11

This view was not particularly important to MH respondents although there were 3 responses from Site 1 and 2 from Site 3. Three (of 8) lecturers and 2 managers/other professionals identified it.

Table 6.34 Views more important to learning disability:

View ID freq (%)	Service - Structure and Process	Practitioner - Personal Characteristics	Education - Aspects of Educational Provision
V 23 MH 0 LD 5 (9)	Minimal representation locally in planning debates.	Finding innovative ways of eliciting views.	How to involve other sectors in community care planning.

View 23

This view was mainly an issue for respondents from Site 4 (4). A third of the lecturers and 2 workers raised it.

A6.15 Prevention and identification of mental illness and learning disability by primary health services (Question W6.15, T.3.2.15, C3.2.11, A4.11, D6.15 and S6.15)

Table 6.35 Views shared between mental health and learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 2 MH 21 (24) LD 15 (25)	Links locally with primary services are good	Understanding the primary health care perspective	Providing clinical supervision and training
V 12 MH 16 (18) LD 17 (29)	No effective links locally		
V 14 MH 9 (10) LD 7 (12)	Specialist nurses attached to primary services	Ability to work in more generalist environment	Training in primary care objectives and working within them

View 2

For MH respondents this view was important in all three sites: 12 in Site 1, 5 in Site 3 and 4 in Site 2 identified it. It was important to managers/other professionals (13), 2 (of 8) lecturers, 4 workers, an advocate and a student group.

Although important to a quarter of all LD respondents, this view was raised mostly by those from Site 4 (11), with 2 responses each from Site 5 and Site 6. A third of the lecturers and 7 managers/other professionals, 2 (of 4) users/carers, 2 workers and 1 student group identified it.

View 12:

This view was most important to respondents from Site 2 (6) and Site 3 (5), with 5 responses from Site 1. Six users/carers identified this view together with 8 managers/other professionals and 2 lecturers. This was not an issue for workers.

Almost 30% of all LD respondents identified this view with the greatest interest being shown in Site 4 (13). Two of Site 5 and 2 of Site 6 respondents endorsed it. Six managers/other professionals, 4 lecturers and a student group expressed this view.

View 14

This view was expressed by 10% of MH and 12% of LD respondents. For MH it was identified by 4 respondents from Site 2, and 4 from Site 1 and 1 from Site 3. For the LD sites it was mainly an issue for respondents from Site 4 (5), with 1 response from Sites 5 and Site 6.

The MH respondents were managers/other professionals (6), 2 lecturers, and 1 user/carer. The LD respondents were managers/other professionals (4), 2 workers and 1 lecturer.

Table 6.36 Views more important to mental health:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 5 MH 13 (15) LD 4 (7)	Some joint training	Open to inter-professional working	Training with district/practice nurses on counselling, stress and crisis intervention
V 8 MH 11 (13) LD 2	GPs refer more to community teams than consultants	Confidence working with GPs	Trained trainers in health promotion, assessment and screening
V 11 MH 9 (10) LD 1	Less serious disorders go undetected	Ability to discriminate between physical and psychological symptoms	Training for GPs in serious problems
V 6 MH 8 (9) LD 4 (7)	Primary services to develop a social model of care	A focus on social and health needs	A social model in a primary setting which promotes healthy living

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View 5

For MH sites, there were 7 responses from Site 1, 4 from Site 3 and 2 from Site 2. This was mainly an issue for (8) managers/other professionals and (4) workers.

View 8:

For MH this view was of particular relevance to those in Site 3 (5), with 4 Site 1 respondents and 2 Site 2 respondents expressing this view. It was mainly an issue for managers/other professionals (8). Two workers identified it with the remaining response coming from a student group.

View 11

Only 10% of all MH respondents expressed this view; 6 in Site 1, 2 in Site 3 and 1 in Site 2. It was mainly an issue for managers/other professionals (7), with 1 lecturer and a user/carer.

View 6

This view was important to a small number of MH respondents: 5 in Site 1, 2 in Site 3 and 1 in Site 2. It was raised by 4 managers/other professionals, 2 (of 4) student groups, a worker and a user/carer.

Table 6.37 Views more important to learning disability:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 9 MH 4 LD 6 (10)	Clear understanding of different sectors of care	Openness to contribution of all sectors	Training in primary, secondary and tertiary care
V 15 MH 3 LD 6 (10)	Placements with primary services	Ability to make users feel relaxed on first presentation to services	Placements promoting a better understanding of primary sector
V 16 MH 4 LD 6 (10)	Purchaser/provider split gives GPs greater power	Ability to market skills	Training in good presentation of what nurses do. Marketing techniques.

View 9

This view attracted: 3 responses from Site 4, 2 from Site 3, and 1 from Site 5. The main respondents were 3 managers/other professionals and 2 workers identified this view.

View 15

As with *View* 9 this view attracted a 10% response rate altogether with 3 from Site 4, 2 from Site 5 and 1 from Site 6. They were 2 lecturers, 2 workers, a manager/other professional and a student group.

View 16

As with the other LD views this was raised by only 10% overall but it was most popular in Site 4 (5). It was expressed by 3 lecturers and 3 managers/other professionals.

A6.16 Cost effective resource management (Question W6.16, T3.2.16, D6.1.6 and S7.16)

Table 6.38 Views shared between mental health and learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 1 MH 6 (8) LD 13 (24)	Nurses lack competence in financial management, audit and evaluation	Aware that training in financial management and audit is essential for positions of responsibility	Training needed in financial management, audit and evaluation, preferably shared with social work

View 1

This view was not so important to MH respondents: 3 from Site 1, 2 from Site 3 and 1 from Site 2. It was mainly an issue for managers/other professionals (4) with a worker and a lecturer.

This view was more important to LD respondents: 7 from Site 4, 5 from Site 5 and 1 from Site 6. Eight managers/other professionals, 3 workers and 2 (of 9) lecturers expressed this view.

Table 6.39 Views more important to mental health:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 9 MH 7 (9) LD 1	Balance necessary between being a caring professional and a cost efficient manager	Retain the caring, humane qualities of the professional while increasing cost efficiency	Training needed in financial management, audit and evaluation, preferably shared with social work

View 9

For MH, there were 3 responses from Site 1 and 4 from Site 2. This was mainly an issue for managers/other professionals (5) with a worker and a lecturer.

Table 6.40 Views more important to learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 5 MH 2 LD 7 (13)	Cost effectiveness and value for money are priorities for efficient service provision	Appreciate the importance of working cost effectively	Management training needed to assure services provide value for money
V 7 MH 3 LD 4 (7)	Dedicated time needed for research and development	Aware of the importance of research to care provision	Research training is a priority for all professionals, preferably shared

View 5

Three responses came from Site 4, 3 from Site 6 and just 1 from Site 5. This was an issue for managers/other professionals (5) and lecturers (2) .

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View 7

This view was important for LD respondents from Site 4 (4) only. Two of these were workers 1 was a lecturer and 1 a manager/other professional.

A6.17 Strategies for evaluating the service (Question W6.17, T3.2.17, D6,.17 and S7.17)

Table 6.41 Views shared between mental health and learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 13 MH 16 (21) LD 10 (19)	Effective monitoring of services. The use of nursing standards and quality assurance.	Not taking quality for granted.	The skills in standards setting, quality assurance and clinical audit
V 10 MH 15 (19) LD 7 (13)	Achievable goal setting and systems to measure success. Targets in terms of both delivery and quality. Attention to customer satisfaction.	The ability to accept failure with honesty.	Skills in auditing and research. Measuring waiting time, throughput and user satisfaction.
V 12 MH 14 (18) LD 10 (19)	Evaluation of outcomes and effective action.	An ability to carefully examine and evaluate sensitive data.	Learning evaluation strategies at basic training. Greater emphasis on qualitative analysis.
V 4 MH 12 (16) LD 9 (17)	Evaluation involving the user. Using structured interventions in order to simplify evaluation.	Ability to encourage participation of those most affected.	Skills in making structured interventions and evaluating care. Skills in user involvement.
V 5 MH 7 (9) LD 5 (9)	Team evaluation preferred involving reflective practice and support for individual workers.	Ability to reflect on one's own performance.	Teaching reflective practice and open debate within supervision.
V 6 MH 6 (8) LD 9 (17)	Continuous review at all stages of the care process. Using evaluation as a mechanism for competing for resources.	Adopting a political approach to evaluation.	Evaluation at all stages including assessment, rehabilitation, care giving and discharge.

View 13

This view was important to MH respondents from Site 1 (10). Four from Site 2 and 2 from Site 3 identified it. It was important for 12 doctors, 3 workers and 1 lecturer.

For LD respondents this view was primarily an issue for Site 4 (8). Only 1 respondent from each of the other sites identified it. It was endorsed by 6 managers/other professionals and 4 (of 9) lecturers.

View 10

This view was primarily identified by MH sector respondents from Sites 1 (8) and 3 (6). It was important to 8 managers/other professionals, 5 workers, and 2 (of 8) lecturers.

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For LD respondents this view was mainly an issue for Site 4 (4). It was also identified by 2 respondents from Site 5 and 1 from Site 6. Four managers/other professionals identified it and also a worker, a lecturer and a student group.

View 12

This was an issue for MH respondents from Site 3 (6), Site 1 (5) and Site 2 (3) . Seven managers/other professionals, 5 workers, a lecturer and a student group identified it.

For LD this view was raised by respondents from Site 4 (6) and Site 5 (4). It was an issue for managers/other professionals (5), workers (2), lecturers (2) and a student group.

View 4

This view was most popular amongst MH respondents from Site 1 (8) and Site 2 (3). It was almost entirely identified by managers/other professionals (11) with 1 worker.

For LD respondents this view was identified by 6 Site 4 and 3 Site 5 respondents. It was important to managers/other professionals (4), lecturers (3) and workers (2).

View 5

For MH this view was identified by 4 Site 1 and 3 Site 2 respondents. It was an issue for managers/other professionals (5), 2 workers and 2 lecturers.

For LD respondents this view was identified by 3 (of 19) Site 5 respondents and 2 (of 9) from Site 6. There were 2 responses each from workers and managers/other professionals and 1 response from a student group.

View 6:

For MH this view was important to 2 respondents from Site 1, 3 from Site 2 and 1 from Site 3. It was primarily an issue for managers/other professionals (5) with 1 response from a worker.

For LD this view was most popular amongst those from Site 4 (6). It was also identified by 2 from Site 6 and 1 from Site 5. It was more of an issue for managers/other professionals (6), with 2 lecturers and 1 worker.

Table 6.42 Views more important to mental health:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 19 MH 9 (12) LD 3	Incorporating a research culture to examine both medical and social outcomes.	A thorough approach is needed both in conducting research and drawing out required action.	Nurses need to learn a variety of research methods including social research methods. Need to develop skills in design, analysis and evaluation.
V 8 MH 8 (10) LD 4 (7)	Evaluation needs to be a contractual requirement between purchaser and provider. Purchasers should monitor and regularly review services.	Aware of the importance of contracting	An understanding of how purchasers may monitor services. Exposure to specimen contracts and an understanding of common contractual requirements.

View 19

For MH this view was identified by 4 respondents from Site 1, 3 from Site 2 and 2 from Site 3. There was a reasonable response from lecturers (3) and managers/other professionals (5) with 1 response from a student group.

View 8:

This view was important to respondents in Site 1 (8). The majority of responses came from managers/other professionals (7) with just 1 response from a worker (1).

Table 6.43 Views more important to learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 9 MH 4 LD 7 (13)	A flexible approach to evaluation is needed. Practitioners need to be reflective and try to evaluate the wider picture.	Nurses need to be able to reflect on their own practice and think in an evaluative way. They need to be adaptive and work with skilled evaluators.	Education should teach evaluation and self reflection.

View 9

This view was identified by 4 Site 4, 2 Site 5 and 1 Site 6 respondent. Three managers/other professionals, 2 workers, a lecturer and a student group identified it.

A6.18 Knowledge of access to records and ease of access (Question W6.18, T3.2.18, C3.2.12, A4.12, D6.18 and S7.18)

Table 6.44 Views shared between mental health and learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 6 MH 32 (36) LD 16 (27)	Sensitive, non-judgmental and confidential approach. Some records may not be available	Tact, sensitivity and diplomacy	Essentials of factual, objective record taking
V 4 MH 22 (25) LD 11 (19)	Clients to be informed about their illness and treatment	Understanding of obligations to user	Education on provisions of Data Protection Act and other legislation. Client empowerment and nurse accountability
V 1 MH 21 (24) LD 9 (15)	Access and rights to information locally supported	Good communication skills	How to inform on access. Care plans as mechanism for user information on illness and treatment.
V 7 MH 8 (9) LD 6 (10)	Poor information services locally. Access is also poor and not encouraged	Consideration of public opinion. Adopting a more closed approach	Debate what is sensitive
V 10 MH 8 (9) LD 6 (10)	Greater collaboration between other professionals and users on record keeping. Possible separation of medical notes	Ability to openly exchange data with a number of groups/individuals	How to operate multi-agency record keeping and incorporate user views

View 6

The view was important in the MH sites: 18 responses from Site 1, 9 from Site 3 and 5 from Site 2. It was an important issue for managers/other professionals (17), workers (10), a quarter of all lecturers and users/carers and 1 student group.

The view was important to over a quarter of the LD respondents: 7 responses from Site 4, 6 from Site 5 and 3 from Site 6. It was endorsed by managers/other professionals (10), 2 (of 4) users/clients, 2 workers, 1 lecturer and 1 student group.

View 4

This view was important to MH respondents: 7 from Site 2, 9 from Site 1 and 6 from Site 3. Twelve managers/other professionals, 4 workers, 3 (of 8) lecturers, and a user/carer, an advocate and a student group identified it.

For LD respondents this view was important to a minority in Site 4 (7), Site 5 (2) and Site 6 (2). It was an issue for managers/other professionals (6) , lecturers (3) and workers (2).

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View 1

For MH respondents this view was important in Site 3 (9) and less so in Site 1 (8) and Site 2 (4). It was identified by workers (9), managers/other professionals (7), users/carers (3) and 2 (of 8) lecturers.

This view was important to some LD respondents: 4 from Site 6, 3 from Site 4 and 2 from Site 5. Five managers/other professionals, 3 workers and a user/carer identified it.

View 7

This view was important to a minority of MH and LD respondents. For the MH sites, Site 1 and Site 3 had 3 responses each and Site 2 had 2 responses. For LD respondents there were 3 from Site 4, 2 from Site 3 and 1 from Site 5.

This view was important to some MH managers/other professionals (4) and MH workers (3); and for LD lecturers (3), a worker, manager/other professional and student group.

View 10:

For MH respondents only Site 1 identified this view (8). Similarly, for the LD respondents this view was mainly an issue for Site 4 (5).

For MH this view was important to managers/other professionals (4), lecturers (2), a worker and a student group. For LD respondents there were 4 responses from managers/other professionals and 2 from lecturers.

Table 6.45 Views more important to mental health:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 5 MH 10 (11) LD 0	Disturbed users should have restricted access	Good judgement on appropriate information giving	Education in what data should be withheld and when
V 9 MH 9 (10) LD 3	Some barriers between agencies to exchanging information. Joint information systems preferred	Openness in the process of exchange	Education on the legal implications of information exchange
V 18 MH 9 (10) LD 1	Clear, written local policies on access	Ability to disseminate complex policy issues	Possible systems of access. CPA guidelines on access
V 2 MH 8 (9) LD 2	Access good but not generally taken up by users	Able to encourage vulnerable individuals to exercise their rights	Other forms of communication, not just written. Client held records
V 3 MH 8 (9) LD 0	Debate on where medical records fit in terms of access		Issues of access to all records or just some

View 5

This view was most important to Site 2 respondents (4) with 3 responses each from Site 1 and Site 3. It was an issue for workers (3), managers/other professionals (5), an advocate and a student group.

View 9

This view was important to respondents from Site 1 (7) and a few from Site 2 (2). A quarter of all the lecturers and users/carers interviewed (i.e. 2 of 8) 3 managers/other professionals and 2 workers identified it.

View 18

This view was expressed by respondents from Site 1 (4) and Site 2 (4). It was mainly an issue for managers/other professionals (6) and student groups (2).

View 2

This view was important to a few MH sector respondents from Site 1 (5) Site 3 (2 responses) and just 1 respondent from Site 2. It was mainly an issue for users/carers (3), workers (3), a lecturer and a manager/other professional.

View 3

This view was important to a few MH respondents: from Site 1 (3), Site 3 (3) and Site 2 (2). It was an issue for workers (4) and managers/other professionals (3).

Table 6.46 Views more important to learning disability:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 21 MH 1 LD 5 (8)	Client held records advocated	Achieving compliance from users on record up-keep	Issues around user held records and problems of update

View 21

This view was important to a few LD respondents particularly from Site 4 (3). Single responses came from Site 5 and Site 6. Two of the 4 users/carers, 2 student groups and a single worker identified this view.

A6.19 Existence of a care plan (Question C3.1)

Only users and carers were asked this question about the existence of a care plan and its value.

Table 6.47 Views shared between mental health and learning disability:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 1 MH 5 LD 1	No written care plan	Unwilling to consult with user and agree the plan of care	Principles and practice of care planning a priority in education programmes

View 1

Site responses: Site 1 = 2, Site 2 = 2, Site 3 - 1, Site 4 = 1.

Table 6.48 Views more important to mental health:

View ID freq (%)	Service - structure and process	Practitioner - personal characteristics	Education - aspects of educational provision
V 2 MH 1 (13) LD 0	No care plan can cause problems for staff and be legally and ethically risky	Unwilling to open care plans to scrutiny	Emphasise the importance of written care plans for information, legal and ethical reasons
V 3 MH 1 (13) LD 0	Family involved in care planning	Willing to involve family in care planning	Emphasise the importance of including the family in care planning
V 5 MH 2 (25) LD 0	Care plans exist and family carers have a copy	Recognises value of collaborative care planning with the user's family carer	Emphasise the importance of including the family carer in care planning
V 6 MH 1 (13) LD 0	Long-term planning often inadequate because services available unknown	Recognises the importance to long-term planning of keeping users and family carers informed about services available	Shared learning so that the full range of services available is understood
V 7 MH 1 (13) LD 0	Care plans held by users can be used as examples of excellence	Willing for care plans to be studied by others	Competent care planning is a priority and awareness of the value of care plans is an indicator of quality
V 8 MH 1 (13) LD 0	The user is involved in the care plan as a contract	Appreciates the value of using the care plan as a contract with the user	Use of care plans as contracts between nurse and user

View 2

Site responses: Site 1 = 1.

View 3

Site responses: Site 1 = 1.

View 5

Site responses: Site 2 = 1, Site 3 = 1.

View 6

Site response: Site 3 = 1.

View 7

Site response: Site 2 = 1.

View 8

Site response: Site 1 = 1.

Table 6.49 Views more important to learning disability:

View ID freq (%)	**Service - structure and process**	**Practitioner - personal characteristics**	**Education - aspects of educational provision**
V 4 MH 0 LD 1	Care planning confirms the user's appreciation of care provision	Understands the value of care planning to users	Guidance on how to involve users/carers in care planning

View 4

Site response: Site 6 = 1.

APPENDIX 7.1

PHASE 3 ANALYSIS AND MODEL DEVELOPMENT (STAGE 2): THEMES DERIVED FROM INTERVIEWS CONTRIBUTING TO CATEGORIES AND THEMES

THEME 1 WORKING WITH OTHERS

CAT1 Responding to the demands of multidisciplinary teamwork

6.2.2 V1J; 6.2.3V1MH; 6.2.1V1J, 5.7V2J
Provision of holistic, client led service requires nurses to lead in health and social assessment and collaboration with others (e.g. to identify unmet needs in the community). Requires pre-registration training in social and health related assessment skills, the scope of service provision and challenges to multidisciplinary working and how these can be met.

6.2.2V3MH; 6.2.8V1J, 6.2.15V16LD, W5.2-5.6V7J, W5.2-5.6V4MH, W5.2-5.6V11J
Professional boundaries maintained within multidisciplinary teams otherwise inefficiency will result. Nurses need to have a clear role identity and avoid becoming 'jacks of all trades'. They must have a strong professional management structure and a clear identity which will persuade other team members and purchaser and provider organisations of the value of their contribution, although some common goals are essential for joint working. Requires education to provide a clear specification of the nature of mental health nursing, the roles of other professions and negotiation skills. (Contrasts with 6.2.2.V1J).

6.2.2V3MH, W5.2-5.6V2J
Organisation of effective interdisciplinary working requires user input. Family and carers involved within multidisciplinary team to ensure effective rehabilitation. Requires education to understand the burden of care and contribution (commitment) of the family of patients with long term illness.

6.2.8V4J
Separate nursing identity is likely to be eroded by increased emphasis on multidisciplinary training and courses leading to dual nursing and social work qualifications. To avoid this requires shared learning between disciplines rather than joint training.

6.2.8V3J, W5.2-5.6V3J

Multidisciplinary team working is best promoted by allegiance to team membership rather than to a single profession and therefore a single management structure that covers all occupational groups. Subordinating professional to service management would ensure equality of status and avoid inter-hierarchical conflict. Requires shared learning to understand the relative merits of professional and service management models and the perspective of other professionals.

6.2.12V12MH

Poor service occurs when nurses are uncertain about the type of information that should be given on users' illness and condition. Requires understanding of how best to co-ordinate views and reach agreement within the multidisciplinary team

W5.2-5.6V5J, W5.2-5.6V10J, W5.2-5.6V16LD

Multidisciplinary working is a requirement for effective community care reform. It enhances an holistic view of clients and ensures that a range of skills is available. Requires a commitment to multidisciplinary working being fostered within education programmes in addition to input on the community reforms and legislative changes.

CAT8 Networking

6.2.2 V4MH; 6.2.3 V7J; 6.2.8 V2MH; 6.2.12V15MH; 6.2.1V2MH, A3.1-3.3V7MH, W5.2-5.6V1J,

Effective networking with voluntary and private agencies and with social services departments and community health care teams. Requires learning how to investigate local activity to find good contacts so improving user choice. Also the use of effective negotiation skills to promote collaboration and an understanding of the health care market - roles of purchasers and providers - and identification of unmet need.

6.2.5V1MH, 6.2.18V10J, 6.18V3MH, 6.2.18V9MH

Networking and liaison requires good record keeping to promote continuity of care. Requires critical review of different record keeping systems including the single multidisciplinary client focused record.

6.2.14V1MH, 6.2.14V2MH, 6.2.14V4MH, 6.2.14V5MH, 6.2.14V6LD

Recognition of the distinct contribution and characteristics of voluntary and private agencies in the LD and MH fields. These organisations are seen to have access to funds not available to the NHS, so their inclusion in planning services would benefit users.

MIND are MENCAP seen as the major voluntary agencies. Requires greater understanding of the organisation, ethos and funding base of voluntary and private agencies, particularly MIND and MENCAP, and ways of involving them in community care planning. Best achieved by greater use of these agencies as practice placements.

6.2.15V2J, 6.2.15V12J, 6.2.15V14J, 6.2.15V8MH, 6.2.15V9LD, 6.2.15V15LD, A3.1-3.3V12LD, 7.1V20J
Need for effective links between primary health care and secondary MH and LD services. Achieved by student placements in primary health care settings and attaching specialist community nurses to primary health care services to support non-specialists' (e.g. GPs, HVs, DNs) work with MH and LD users. Requires specialist community nurses to be trained in primary care objectives, the challenges of working in a generalist environment and confident in advising GP on health promotion, assessment and screening for MH/LD users.

C3.1V6MH
Long-term planning is often inadequate because services available are often unknown. Requires understanding of the importance of good networking to understand the range of locally available services.

5.8V5MH
Good multi-agency referral strategies needed to avert crises for clients. Requires understanding of principles and practice of crisis intervention and knowledge and skills of other professionals and agencies.

THEME 2 CLINICAL PRACTICE

CAT12 Learning in practice settings

6.2.4V10J; 6.2.5V9MH
Effective learning requires placement in good service settings that provide supportive mentors who encourage students to draw upon theory in their practice. Requires classroom teaching of theory which is critically evaluated in relation to practice. Also requires continuing education to enable practitioners to keep up to date and develop mentorship skills.

7.1V13J

Community services are increasingly the primary site of nurse training rather than the hospital ward. Requires development of placements outside hospital settings and supervision methods which enable students to take on increased responsibility for users.

7.1V17J

High quality services need effective clinical assessment of students which incorporate an assessment role for service users. Clinical assessment of students should be incorporated within clinical audit programmes. Requires lecturers to collaborate with service providers to develop and test clinical assessment strategies which incorporate users' views.

S5a, S5bV1-17, S3V1-V10, S3V15

Students' perception of aspects of courses helpful to client care included comments on learning environments:

- A&E experience prepares student to manage medical emergencies and associated emotional crises
- medical ward experience to understand medical problems of people with mental illness and give a broad understanding of health and health promotion
- acute psychiatric ward experience provides a range and intensity of learning opportunities not possible in community settings. What is important is that students have experience of their own caseloads and continuity of client care in the community and also experience of acute and intensive care in hospitals. The importance of students being able to follow their clients into and out of hospital was emphasised
- voluntary sector exposes students to a social rather than medical model of care
- working in a poor learning environment has some positive benefits for learning because it increases awareness of what can be achieved in high quality care environments.
- depot-clinics are a poor learning environment because of their production line processes
- clinical support for students needed from college lecturers to exploit learning opportunities
- clinical placement staff need continuing education to keep them up-to-date.

CAT24 Support of professionals

5.8V3MH

Nurses have to cope without a heavy workload without adequate training and support. There is an urgent need for support groups for nurses to help them cope. Other professionals in the field have access to support groups but not nurses. Requires training in running support groups and methods of clinical supervision.

CAT17 Management and support of non-registered care staff

6.2.9V3J, 6.2.7V5MH, 7.3V5MH

Management and supervision of support workers is integral to the nursing role. Requires management skills training addressing clinical supervision, delegation whilst retaining responsibility and a sound knowledge base to be able monitor performance and ensure high standards of work.

6.2.9V8J; 6.2.9V16J

Induction programmes for support workers and training on-the-job are essential to ensure high care standards and staff support. Requires knowledgeable trainers who are clinically credible and external training leading to vocational qualifications.

6.2.9V1J, A3.1-3.3V13LD

Care assistants are the backbone of the service and often feel undervalued by care managers. Acknowledging the value of practical wisdom of mature support workers who take a flexible approach to client care. Requires learning how best to recognise and channel the insights of support workers into care programmes.

6.2.9V22J; 6.2.9V4MH, A3.1-3.3V11LD

Care assistants often have unrealistic expectations of clients' abilities because they are unaware of the full impact of arrested development. Getting the best out of support workers requires assessment of their practical competence and supportive supervision to ensure that they work within their abilities. Requires skills in boundary setting and task clarification and modification of post-registration training courses (e.g. ENB Course 998) to ensure greater emphasis on the needs of support workers and their practical skills.

6.2.9V17J

Inclusion of support workers as full and members of the multidisciplinary team and recognition of their contribution. Requires skills in team working and leadership.

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6.2.9V5MH

Understanding by nurses of the skills of NVQ qualified workers and the links with nursing competencies. Requires knowledge of NVQ training and the requirements needed to act as supervisor, mentor, teacher and assessor. And to critically consider the merits of a system of integrated preparation that links vocational and professional qualifications.

THEME 3 LEARNING FORMATS

CAT2 The foundation disciplines

6.2.2 V9J

Depth knowledge of psychiatry needed to inform understanding of psychiatric assessment and prescription. Will give nurses sufficient knowledge to question when necessary.

6.2.3 V9J; 6.2.5V5MH, 7.1V24LD

Services are likely to have increasing statutory responsibilities and powers. This changing context requires that nurses keep up to date with developments in policy and legislation. For example knowledge of the Mental Health Act, the NHS & Community Care Act and other legislation is a prerequisite for sound decision making.

7.1V12LD

Health education and illness should assume increasing importance in education programmes and service delivery.

S5a, S5bV1-17, S3V1-V10, S3V15

Students' perceptions of aspects of courses helpful to client care included (Applies to MH unless otherwise indicated):

Knowledge

- nursing rather than medical knowledge for holistic care
- theories of psychology and sociology to understand individuals within their social contexts and social inequalities to health
- mechanisms of service delivery
- principles of normalisation and integration (LD)

A3.1-3.3V3MH
Advocates raised the importance of social and psychological models of care as well as the medical model. Requires education in a range of care models.

CAT13 Lecturers and teaching

5a, S5bV1-17, S3V1-V10, S3V15
Students' perceptions of aspects of courses helpful to client care included (Applies to MH unless otherwise indicated):

Skills

- interpersonal and communication skills through videoed role play
- value of counselling and therapy courses to practice
- managing challenging behaviour is a priority for LD nursing practice (LD)
- clinical supervision skills
- care planning skills

Design of curricula

- nursing placements have to be long enough to promote continuity and be a worthwhile experience. Some students were critical of nursing placements in comparison to social work placements.
- guidance to help students to make the right selection of branch programme
- the CFP is general nursing oriented and does not prepare students for the minority branches. They suggested shortening the CFP and lengthening the branch programme
- students were conscious of lack of academic equivalence between university based and school/college of nursing based teaching.
- colleges of nursing must design courses with purchasers' (of education) requirements in mind to ensure that students' education meets service requirements.
- availability of course electives for students to gain additional qualifications during pre-registration training e.g. in counselling.

CAT18 Shared learning

6.2.13V1J, 6.2.13V2J, 6.2.13V7J
Benefits of multidisciplinary education to service users, providers and their practice. In particular shared learning promotes team building, policy consistency, and understanding other professional roles. Pre-registration shared learning is best undertaken in practice

settings. Recommended at post-basic level generally. Requires exploring opportunities for shared learning within and across teams and professions.

6.2.13V5J, 6.2.13V9J; 6.2.13V4MH, S3V12LD
Shared learning has the advantage of creating generic workers and avoiding professional exclusivity. The opposing view supported shared learning as long as professional boundaries are retained and nurses maintain their separate identity. The production of generic carers was not favoured. Some students raised the disadvantage of joint LD/social work courses as that jobs for combined skills are not available so students must decide whether they will take jobs as nurses or social workers on qualifying. Requires consideration by the professions of the purposes and products of shared learning and its distinction from joint training.

6.2.15V5MH
Shared learning between primary and secondary care providers will promote integration between primary and secondary health care services. Topics ideally suited to shared training include counselling, stress management and crisis intervention.

THEME 4 USER ENABLEMENT AND EMPOWERMENT

CAT5 Advocacy

6.2.11V6J; 6.2.11V3J, A3.1-3.3V6MH, A3.1-3.3V10J, A3.1-3.3V9MH, A3.4V1MH, A3.4V2MH
Advocacy should be represented within service structures. Users need advocates who are independent of service delivery. Ex-users as advocates is a good idea because of their insight. Nurses should not be advocates themselves but should refer users to independent advocates if necessary. These services require dedicated resourcing. Requires nurses to understand the role of advocacy and brokerage, the value of ex-users as advocates and the need for an independent and unbiased approach. A good subject for debate in education programmes.

6.2.11V8LD, A3.1-3.3V5MH, A3.4V3MH
Advocacy was seen to be a central feature of the nursing role. Nurses advocate on clients' behalf in negotiating with other professionals. Requires communication, lobbying and negotiation skills and emphasis on the potential and challenges of the nurses' advocacy role (In contrast to 6.2.11V6J).

CAT17 Outreach

6.2.1V20LD, 7.1V19LD
Out of hours and other outreach services that are developed in consultation with users are essential for meeting their unmet needs. Requires skills in lobbying to mould services to meet users' requirements.

CAT25 Empowerment strategies

6.2.2.V13LD; 6.2.5V6MH, 7.1V14J
Offering users choice by providing a range of treatment and therapy options and discharge plans. Requires education on principles of user empowerment and their practical application, and the appropriateness of specific treatments and therapies.

C2.2.1V3MH
Clients and carers stressed the importance of negotiating their medication regimes with CPNs. Requires debate on alternative action in cases of non-compliance (e.g. negotiating with the client to continue contact with the CPN when refusing medication).

6.2.3V6LD
Separate funding reduces likelihood of cooperative client-led care planning. Requires shared learning to understand the collaborative construction of client-centred care plans.

6.2.5V7MH
Services require assertive confident nurses able to successfully challenge treatment decisions (e.g. discharge plans) in the interests of clients. Requires training in marshalling facts and presenting an argument on behalf of clients.

6.2.10V7J, A3.1-3.3V8MH
Participation encouraged by establishing trusting relationships with clients and working with user groups. Requires shared learning of therapeutic group work and group dynamics and the value of the therapeutic rélationship.

6.2.10V8J
Professional judgement is not eclipsed by users' demands. Requires ability to present professional judgement in the clients' language.

6.2.10V10J
Inclusion of users in curriculum development and teaching staff. Requires user involvement in education programmes so that nurses appreciate their perspective on service provision, particularly nursing care.

6.2.11V1J; 6.2.1V8LD, A3.1-3.3V1MH, A3.1-3.3V2MH
Empowering users by keeping them informed of their care and their rights and encouraging them to express their unmet needs. Requires knowledge of users' rights and how to support users to speak up for themselves.

6.2.11V7MH
User empowerment is seen to be successful when users start challenging care and treatment regimes. Requires nurses to learn to help users to influence their care and treatment without invoking defensive reactions from staff.

5.7V4MH
Present services involve multidisciplinary teamwork which may exclude users from decision making. Overcome by involving users or user advocates in running mental health services. Requires students being exposed to examples in practice of how user choice and power can be exercised.

Practical assistance (e.g. help with letter writing, form filling and dealing with agencies) and provision of information on local services and resource availability was highly valued by users and carers for improving quality of life.

6.2.12V13MH, 6.2.18V6J, 6.2.18V21LD
Respect for user empowerment requires sensitivity and tact in written user held records. Whenever possible users should hold their own records. Requires training in the proper content of written records (e.g. separating fact from value judgements).

6.2.18V4J, 6.2.18V1J, 6.2.18V7J, 6.2.18V2MH
The record is a source of information for users about their illness, treatment and progress. Requires knowledge and respect for user access and rights to information under the Data Protection Act and ensuring that users know about this. This is a right little used.

6.2.18V5MH, 6.2.18V18MH
Disturbed clients should have restricted access to their records. Requires understanding of the negative as well as the positive effects of information from records for clients and

need for a clear written local policy on access together with guidelines specific to the CPA.

C3.1V1J, C3.1V5MH, C3.1V3MH, C3.1V2MH

Some clients and carers report no knowledge of a written care plan. Others are aware and make use of them and are involved in writing them. Clients and carers noted the ethical and legal risks of there being no care plans open to scrutiny. Requires understanding of principles and practice and importance of writing care plans in collaboration with users.

C3.1V8MH, C3.1V4LD

Carers and clients report that the advantages of involving users in the care plan as a contract. It enables them to appreciate the rationale for care and why certain services are not open to them. Requires understanding of contracting as a component of care planning.

CAT4 Rights and risks

6.2.2 V5MH

Risk assessment in co-operation with patients is a prerequisite to enable clients to cope with crises related to their illness and promote rehabilitation. Requires training in risk assessment and management, safety and break-away techniques for responding to unpredictable behaviour.

6.2.7V8J

User led approach entails achieving a balance between risk and benefit necessary for ordinary living. Requires accepting that a level of risk is necessary for well-being and flexible open-minded attitudes to a user led service.

THEME 5 RESPONDING TO THE MARKET AND SERVICE PRIORITIES

CAT20 Service evaluation

6.2.10V10J; 6.2.12V5MH; 6.2.17V4J

Inclusion of users in monitoring service quality and establishing mechanisms for this (e.g. complaints procedures). Requires good understanding of quality assurance programmes and how to involve users.

6.2.14V13MH; 6.2.17V13J, 6.2.17V10J, 6.2.17V12J, 6.2.17V6J, 7.1V8LD

Nurses have a role in monitoring the quality of service provision, striving for continuous improvement and user satisfaction. Requires an understanding of monitoring, quality assurance and clinical audit methods including outcome measures all of which can be used in competing for scarce resources. Extends to monitoring the quality of services provided by voluntary and private agencies. Requires also an understanding of the agencies' contractual obligations and priorities (e.g. a profit motive, pressure group activity to improve standards of existing services).

6.2.17V5J, 6.2.17V9LD

Team evaluation of its service involves reflection on practice by individuals within supportive atmosphere. Requires learning reflective practice and methods of building supportive teams.

6.2.17V19MH, 6.2.16V7J

Evaluating medical and social outcomes of health care requires commitment to research in practice and dedicated time for this. Requires knowledge and training in research methods and their contribution to evaluating practice.

6.2.17V8MH

Evaluation using clinical audit techniques is a requirement of contracts between purchasers and providers. Requires an understanding of the purchasers' role in monitoring service quality and familiarity with contracts and contracting.

C3.1V7MH

User held care plans are an indicator of high quality service which could be used in purchaser-provider contracts. Requires competent care planning skills and awareness of their value in making service quality transparent.

5.7V13J

Models of service delivery need to be tested for their ability to meet user needs. Requires education to encourage critical appraisal of service delivery grounded in clinical experience.

A3.1-3.3V14LD

Living in the community may result in high levels of inactivity for profoundly disabled clients in comparison with their previous institutional life, particularly outside conventional working hours. The solution is flexible services and transfer of the positive features of institutional life to the community. Requires training in therapeutic activities and service development relevant to profoundly disabled clients.

6.2.12V16LD
Computers facilitate information storage and dissemination to users. Requires training in IT.

CAT22 Balancing the budget

6.2.16V1J, 6.2.16V5J, 6.2.16V9J, 7.1V1J
Cost-effectiveness and value for money are priorities for efficient service provision within a competitive market and nurses lack confidence in this. A balance is needed between being a caring professional and a cost efficient manager. Requires training in financial management, audit and evaluation to ensure services provide value for money, and marketing the service.

CAT3 Priority areas for service delivery

6.2.2 V6MH
Increased need for intensive support by specialist teams for people with non-psychotic long term mental illness. Requires skills training oriented to client need and long term support.

6.2.15V11MH
People with serious mental health problems go uneducated by primary health care teams. Requires training for primary health care nurses in identifying clients with serious mental health care problems and ability to distinguish symptoms with a physical base from those with a psychological base.

6.2.2.V13LD
Provision of a service to meet the needs of users with multiple disabilities. Requires a broad curriculum which draws upon mental health, learning disability and general nursing.

6.2.6 V1J
Awareness of cultural diversity without leading to block treatment. Requires understanding the cultural and ethnic similarities and differences within and between ethnic groups and the meaning of LD and mental illness within different cultures.

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6.2.6 V3J

Need for nurses from ethnic minorities who are bi- or multi-lingual. Requires recruitment policies to target black and Asian groups and challenging stereotypes of nursing held by them. Also language electives advisable in pre- and post-registration education.

6.2.6V2J

Emphasis on ethnic minority cultural influences as they affect daily life. Requires learning to be grounded in everyday life styles of different cultures.

6.2.8V6J

Danger of discriminatory and/or oppressive practice towards ethnic minority users. Requires racial awareness training with social workers that highlights the ubiquitous nature of racial prejudice.

6.2.1V4MH; 6.2.1V13MH

Emphasis on providing ethno-sensitive services and targeting them to ensure the needs of people from ethnic minority groups are met. Requires understanding of targeting strategies.

6.2.10V2J; 6.2.12V2J; 6.2.12V6J; 6.2.12V8J

Keeping carers and users fully informed of aetiology of client's ill health and treatment programmes is an important aspect of family support. Requires family placements for students to acquire skills in information giving, family liaison, different information giving strategies and an understanding of the pressures on families imposed by an ill or disabled relative.

6.2.10V11J

Psychosocial interventions with families help them manage anxiety and stress of caring. Requires training in psychosocial care, family therapy and stress management.

THEME 6 VALUES

CAT19 Values underpinning care

6.2.15V6MH

Social factors influence the lives of people with mental illness and/or LD and primary health services should seek to address these. Requires that nurses understand the dynamics between health and social factors and how these might be addressed to promote healthy living.

6.2.7V1MH
Life styles of clients should only be of concern when there are implications for health. Requires toleration and open-mindedness to the way people live.

CAT7 Therapeutic allegiances

6.2.2.V13LD
Therapies for LD services are dominated by behaviourist theories which may not acknowledge user choice. Requires consideration of alternative therapeutic approaches.

THEME 7 THE IMPACT OF NEW MODELS OF CARE AND FUTURE DIRECTIONS

CAT11 User assessment

6.2.4V17J; 6.2.1V10J; 6.2.1V5LD
Users need comprehensive assessment as a precursor to setting goals, intervention and evaluation. Requires critical knowledge of range of assessment methods and measures that address health and social care, and skills in their application.

6.2.4V7J; 6.2.1V12J
Move to client-led assessment of needs, rather than problem-based assessment, with as much user involvement as the client wishes. Requires adapting assessment to individual need and learning how to encourage vulnerable people to participate, particularly those with enduring mental illness or who exhibit challenging behaviour.

6.2.4V24J
Assessment of clients' rehabilitation and long term needs requires improved liaison between hospital and community services. Requires ability to undertake assessment with the client and shared action planning with hospital and community providers.

6.2.4V22J; 6.2.5V2J

Value of standardised assessment to joint purchasing and care provision so ensuring best use of resources. Requires shared learning with occupational groups focusing on multidisciplinary assessment packages.

6.2.4V1MH; 6.2.4V2MH

Recognition of the need to modify standard assessment tools to accommodate professional judgement of user need. It may be appropriate to modify tools to meet local requirements. Requires good knowledge base to give practitioners confidence in their professional judgement so enabling comprehensive assessment. Also requires some knowledge of instrument development and validation techniques.

6.2.4V4MH

Good information of the background of users at referral minimises risks of violence to both assessors and users. Requires knowledge of safety precautions, particularly on home visits, and predictors of aggression.

6.2.4V6MH; 6.2.4V8LD

Skilled assessors probe at assessment without being confrontational. Requires training in the art of assessment and interviewing, in particular creating an informal atmosphere and listening skills.

6.2.4V18LD

Assessment by nurses should be sufficiently comprehensive to cover physical, psychological and social assessment when appropriate. Requires a good knowledge of assessment processes and procedures.

6.2.5V3J

Effective community discharge planning is incorporated into the assessment process from admission onwards and includes liaison with all agencies that will be involved after clients are discharged. Requires knowledge of the wide range of services available.

6.2.11V7J

Immediate assessment is needed for rapid referral to appropriate professional(s). Requires knowledge of the range of services available and professional role boundaries.

6.2.1V9J

The purchaser-provider split has increased awareness of the importance of identifying unmet need in the community. Requires education on community needs assessment.

CAT9 Care/case management and different levels of user support

6.2.3 V4J; 6.2.5V4MH, A3.1-3.3V4MH, 5.8V20MH

Responsible key worker ensures continuity, accountability and evaluation of care, including discharge planning. Requires skills in holistic assessment (levels 1 and 2), evaluation and the care programme approach.

6.2.3 V2J

Nurses as case managers can simultaneously provide hands-on care whereas vesting case management responsibility with social services cannot. Requires input on the relative merits of different approaches to case management.

6.2.3V12LD

The complexity and variety of case management requires knowledge gained through practical experience where different models of case management are in operation.

6.2.1V7MH

Cost-effective management of resources. Requires understanding of the conflict between scarce resources and increasing demand due to rising expectations.

6.2.7V2J, 6.2.7V6J

Proactive resourcefulness makes best use of the service infrastructure for the benefit of users. Requires nurses to be proactive initiators rather than reactive copers in effective networking of available services and to see possibilities beyond the stereotyped service.

6.2.3V5LD, 6.2.7V9LD

Case management models lack coherence without proactive nursing. Requires nurses to have a comprehensive knowledge of the range of services available on which to draw and how to put pressure on agencies to meet individual clients' needs.

CAT23 Genericism and specialism and the future of MH and LD specialties in nursing

7.3V1J, 7.3V9J, 7.3V4LD, 5.8V9J, 5.8V25LD

Nurses seek a role distinct from other professions that collaborates with others but avoids the isolated working characteristic of the past. Community nurses are ideal as generic carers, particularly in LD, and should accept this unless they can adequately define a unique nursing role. Some saw the necessity of moving away from the traditional hands-on care role towards the coordinating role of the case manager. Requires an adaptive, flexible and non-territorial approach to role development. Also knowledge of case management, networking and staff supervision which will prepare them for service management.

7.3V2J, 7.3V3MH, 5.8V6J, 5.8V15LD, 7.1V11J
Nurses seek a role distinct from other professions that carves out a distinct clinical specialism. Avoids genericism and resultant de-skilling which will be unattractive to purchasers and providers. Requires pre-registration courses to introduce clinical specialism and post-registration courses to consolidate these e.g. challenging behaviour, forensic psychiatry and specialist therapies.

7.3V6MH, 5.8V11J, 7.1V2J, 7.1V5LD, W5.2-5.6V6J
Social services departments' responsibility as lead providers promotes development of generic roles for nurses which entail going beyond health to incorporate social assessment and interventions, and some medical and clinical psychology skills so providing truly holistic care. This kind of collaborative working enhances efficiency and effectiveness of the care process by pooling skills. Requires a broad based education and shared learning that incorporates health, medical, psychological and social care and social policy and respect for the knowledge base of different professions.

7.3V7LD, 5.8V7J
The focus of future development of the nurses should be health based rather than extending into social care. Requires training which emphasises ways in which the negative impact of illness and handicap can be lessened. Medical sciences should remain integral to nurse education.

7.1V7J
Uncertainty about the future orientation of health and social services was emphasised. The current trend towards genericism in community teams, in which medicine receives little emphasis in the social care oriented service, might disappear in favour of a more illness oriented service. In this case the biomedical traditions of nursing will re-emerge. Requires nurses to maintain knowledge and skills in the basic medical sciences.

7.1V9MH
Community based services, and thus the nurses' role, will be determined by an emphasis on users with challenging behaviour or long term mental health problems. Preparation of nurses to work with these priority groups is crucial.

5.8V10J

Some respondents expressed the view that nursing has changed hardly at all since the NHS & CC Act. The roles and responsibilities of nurses remain the same as they were before. This suggests that changes in response to the move to a community based service had already occurred before the Act and the Act served to validate them.

7.1V4J

Concern was expressed that, because of the emphasis on community care, residential care skills are being lost and standards are declining. Requires emphasis on residential as well as community care in pre-registration education.

S3V11LD, S3V13LD S3V14LD

LD students identified a closer affiliation with social work than with other branches of nursing. Some argued for removing LD nursing from the nursing family and affiliating it to social work training. This would raise the academic level of LD nursing to that of social work and provide access to a greater number of high calibre social work placements for LD students.

ENB

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TWENTY TWO

NOVEMBER 1996

The changing educational needs of mental health and learning disability nurses

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Abstract

The purpose of this study was to identify and explore the changing educational needs of mental health and learning disability nurses following the 1990 NHS and Community Care Act.

The research followed a process of empirical enquiry to discover what was happening in mental health and learning disability services, and development work to build models of educational provision for use by policy makers, practitioners and lecturers.

These Research Highlights include the main findings – requirements for skilled practice and implications for education – specified under seven themes, and the models of education that were developed from the findings. A brief description of the methods follows the findings. *r*

Main Findings:

requirements for skilled practice and implications for education

Requirements for skilled practice and implications for education are presented under seven themes. Many requirements are similar for both mental health and learning disability nursing practice although the details will differ according to the user group and location of care. For each theme we present the findings for both mental health and learning disability nurses first followed by those that emerged, if any, for each group separately.

Theme 1: working with others

Nurses need:

- inter-professional and multidisciplinary teamworking skills
- confidence and knowledge to act as specialist advisers to non-specialists and commissioning agencies on service planning and specific clinical issues
- knowledge and skills required to undertake a community profile
- knowledge of ways to involve users and carers as members of multidisciplinary teams
- multi-professional assessment and care planning skills
- knowledge of the policy context of care
- networking skills
- team-building skills.

Mental health nurses need:

- to create effective multi-agency working across the statutory and voluntary services
- specialist therapeutic skills which contribute to the 'skills bank' of the multi-professional team
- to work relatively autonomously as case managers and key workers within a multi-professional team
- knowledge and skills to execute effective discharge planning.

Learning disability nurses need:

- to be proactive in co-ordinating multi-professional services
- effective inter-agency liaison skills.

Implications for education include: teaching methods that reflect realities of practice; thorough grounding in therapeutic interventions; understanding professional roles and responsibilities; shared learning to foster collaborative working; and team training.

Theme 2: clinical practice

Nurses need skills to:

- develop their professional practice
- manage and lead professional practice
- develop staff
- manage themselves
- support, monitor and assess staff undertaking vocational (NVQ) qualifications.

Implications for education include: clinical placements that are family-based, reasonably long and in innovative services; clinical supervision that provides a role model and allows the student to 'experiment' and take responsibility; lecturers who work closely with providers on clinical assessment strategies, take a small caseload, and have consultation and research skills; recruitment policy to consider student recruitment to dedicated mental health or learning disability programmes: feasibility of transfer between NVQ training and professional education: and continuing education for practitioners to update and develop supervision skills.

Theme 3: learning formats

Curriculum content valued by respondents:

- General aspects of pre-registration courses:
    - skills of critical analysis and basic scholarship
    - numeracy skills and basic statistics
    - anti-discriminatory practice
    - skills for self-directed learning
    - skills in self-presentation
    - problem-solving skills
    - a liberal university education which allows students to appreciate the profession within its social and political context.
- Aspects of pre-registration education relevant to mental health and learning disability nursing:
    - interpersonal communication and counselling skills
    - teaching and health education skills
    - how to be a resource to other professionals
    - knowledge necessary to help clients with activities of daily living
    - working with groups
    - positive attitudes towards users and principles of care
    - skills and principles of case and care management
    - skills relevant to the needs of priority client groups.
- Specific to mental health nurses:
    - knowledge of basic anatomy and physiology with specific attention to neuro-pharmacology and basic neuro-psychiatry.
- For learning disability nursing:
    - skills relevant to people with challenging behaviour or severe handicap
    - knowledge of abuse and the advocacy role of the nurse
    - skills relevant to the expression of sexuality and spirituality.
- Shared teaching in post-registration education on:
    - psychopathology of mental disorders
    - therapeutic interventions
    - particular aspects of care and treatment (e.g. courses on child protection)
    - keyworking and case management
    - staff retraining for community care
    - financial budgeting
    - management and leadership skills
    - legal issues
    - principles and practice of research
    - counselling
    - stress management
    - crisis intervention.

Implications for education include: lecturers who are graduates, clinically qualified and experienced, enthusiastic, confident and credible, and interested in clinical practice and/or research as well as teaching; colleges that maximise career development for teachers and explore the potential of joint appointments; student-centred experiential teaching methods; computer-assisted learning; and curriculum planners to continue the debates on single discipline versus applied subjects, and shared learning and joint training.

Theme 4: user enablement and empowerment

Nurses need to:

- recognise user empowerment and advocacy as fundamental to the new relationship between user and nurse
- form collaborative and empowering relationships with users
- engage clients and carers in their care in ways that are acceptable to them
- exercise influence on the political process to improve services for clients
- understand the nurse's role in relation to advocacy
- keep clear written records
- use the case record to promote user participation
- be skilled in giving information to users and carers
- ensure informed consent
- be knowledgeable about welfare rights and assist service users to claim benefits.

Mental health nurses need:

- the ability to empathise accurately with users and thus appreciate their needs
- skills in psycho-educational models of family work to promote awareness and collaboration
- to offer and facilitate user choice.

Learning disability nurses need:

- skills in forming collaborative and empowering relationships with people who exhibit challenging behaviour
- sophisticated and wide ranging negotiation and communication skills to ensure participation
- information technology and publishing skills to improve clarity of information for users
- health promotion and health oriented care skills.

Implications for education include: curriculum content relevant to skilled practice including principles of care and values clarification, user empowerment strategies, health promotion and knowledge of users' needs, treatments and prognosis; involving users in curriculum planning, teaching, assessing students and course review.

Theme 5: responding to the market and service priorities

Nurses need:

- skills concerned with developing and sustaining services which are relevant and responsive to user need and purchasers' requirements
- skills concerned with maintaining and improving service quality
- to provide culturally sensitive services.

Mental health nurses need:

- to be able to evaluate the Care Programme Approach
- skills relevant to the care of people with severe and enduring mental health problems.

Learning disability nurses need:

- long-term care skills with users with multiple needs
- therapeutic skills including sensory stimulation techniques
- generic medical skills for users with multiple needs
- to be able to respond effectively to challenging behaviour by drawing on evidence-based interventions.

Implications for education include: a curriculum that contains social and health policy, current methods of care organisation (case management, key-working, multi-professional working); measures to promote ethnosensitive care; colleges that respond to purchasers' and service priorities and expertise, and reflect the demands of the market; and a fail-safe mechanism for funding vulnerable minority branches.

Theme 6: values

Nurses need to:

- value the perspectives of users and carers and their rights to good quality services
- respect other professions and team members and be willing to work flexibly with them
- tolerate and be open-minded to alternative lifestyles which do not threaten health
- be committed to mitigating social factors which have a negative impact on mental health.

Mental health nurses need to:

- value the standards and expectations of users
- be committed to user empowerment
- ensure confidentiality of user information within the health care team
- be committed to the welfare of people with serious and enduring mental health needs
- be committed to open and honest relationships with users and carers based on trust and respect.

Learning disability nurses need:

- commitment to implementing change indicated by service evaluation
- skills in analysing the ethical dilemmas facing community practitioners
- commitment to maintaining people with multiple disabilities in community care settings.

Implications for education include: exploring values related to discriminatory practices, normalisation and ethical reasoning.

Theme 7: impact of new models of care

Nurses need:

- case management skills
- to contribute to collaborative assessment with other workers using established protocols for multi-professional assessment.

Mental health nurses need:

- risk assessment and management skills
- to be able to assess dependency and recognise prodromal symptoms indicating relapse and self-harm
- to be able to prioritise their caseload.

Learning disability nurses need:

- to be able to assess challenging behaviour
- skills of service brokerage
- clinical case management skills in the context of legislation and statutory responsibilities.

Further information

For copies of the full report of the study and the Research Highlights, please contact:

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Implications for education include: curriculum content that emphasises clinical assessment at the individual, family and community level; clinical knowledge and supervised practice that enhances self-assessment, self-confidence and initiative; student exposure to different service delivery models; role development and managing change.

Models of educational preparation

The findings from the empirical work led us to identify five models of educational preparation. Two are independent of each other: the 'specialist model' and the 'generic model'. The other three are variations of these two: the 'pragmatic model', the 'unity-of-nursing' model and the 'social care model'. The pragmatic and unity-of-nursing models support the existing DipHE programme, the specialist and generic models depart from DipHE and the social care model applies principally to learning disability nursing.

Method

The research design and methods followed a process of empirical enquiry, to discover the views of mental health and learning disability stake-holders, and development work to build models of educational provision to inform policy makers, educationists and practitioners. The design took an 'embedded multiple-case study' approach as described by Yin (1989) in which there were two 'cases': one in mental health and the other in learning disability service provision. 'Multiple data points' were represented by respondents in three sites in each case – three in mental health and three in learning disability. In undertaking this process of field research and development, we engaged in the following activities:

- interviewed 45 key informants whose perspectives were important in identifying the substantive issues about service provision and their educational implications;
- explored provision of services from the perspective of 147 stake-holders (care providers, managers, purchasers, teachers, students, service users, carers, advocates) in three mental health and three learning disability services in England selected for their diversity;
- identified views that emerged from the data, for mental health and learning disability, which we describe in terms of their service, practitioner and educational implications;
- identified issues from the views and clustered them into categories and themes;
- specified the implications of the findings for education of mental health and learning disability nurses;
- built normative models of nursing education for consideration and debate.

Details about the project

The team set out to identify the changing educational needs of mental health and learning disability nurses. The objectives were to:

- identify community care settings characterised by progressive care practices which reflect the substance and spirit of the NHS & Community Care Act (1990)
- explore service implications of the Act for practice and relevance to contemporary educational provision.

The two-year study was commissioned by the ENB in 1993. The approach taken followed three phases:

- *Phase 1: preliminary work* included four activities: collecting information on educational provision; discussions with key informants; selecting sites; and developing interview schedules.
- *Phase 2: fieldwork* in six sites took place between November 1993 and October 1994. We interviewed 147 people: 88 in mental health and 59 in learning disability services.
- *Phase 3: analysis and model development* included two stages: we identified categories and themes from views about mental health and learning disability service provision and specified their educational implications; and developed normative models of nursing education for consideration and debate.

The findings have particular significance for lecturers and educational policy makers concerned with mental health and learning disability care.

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